November 6, 1998

Attorney General Christine Gregoire
Office of the Attorney General
Highways-Licenses Building
PO Box 40100
Olympia, WA 98504-0100

Re: Tobacco Task Force Report

Dear Attorney General Gregoire:

As the co-chairs of the Attorney General's Task Force we are pleased to transmit our final report to you, entitled, *A Comprehensive Tobacco Prevention and Control Plan for Washington State*.

The Task Force was charged with developing recommendations for a comprehensive tobacco prevention and control plan for Washington state. You asked us to develop strategies and recommendations for underage tobacco use prevention, cessation, public education and youth access.

We believe this report provides a comprehensive tobacco prevention and control plan based upon programs that have demonstrated their effectiveness. The report provides documentation of effective programs and recommends a budget to fund such efforts in Washington.

On behalf of the Task Force, thank you for the opportunity to participate in crafting a plan for Washington. In the event of a settlement or a favorable verdict in the state's case, we hope to put the restitution to work remedying the harm caused by the industry's misconduct. We look forward to working with you to make these recommendations a reality and to make Washington a healthier state.

On Behalf of the Task Force,

Robert Jaffe, MD
Maxine Hayes, MD, MPH

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Introduction

In the spring of 1998, Attorney General Christine Gregoire appointed a Tobacco Task Force to advise her on a comprehensive and sustained tobacco prevention and control plan for Washington state. The Task Force was co-chaired by Dr. Robert Jaffe representing the Washington State Medical Association, and Dr. Maxine Hayes from the Washington State Department of Health. The members were selected for their experience and expertise in public health and tobacco matters. Experts were drawn from the American Cancer Society, American Heart Association, American Lung Association, local health departments, the Comprehensive Health Education Foundation, the Department of Social and Health Services, Fred Hutchinson Cancer Research Center, The Governor's Office of Health Policy, Group Health Cooperative, the Office of the Attorney General, the Office of the Superintendent of Public Instruction, the Sisters of Providence, Tobacco Free Washington, the Tulalip Tribe, the School of Public Health and Community Medicine at the University of Washington, Virginia Mason Hospital, Washington DOC, Washington State Black Health Professionals Association, Washington State Board of Health, Washington State Department of Health, Washington State Hospital Association and the Washington State Medical Association. A membership roster and brief biographical sketches are contained in the Appendices.

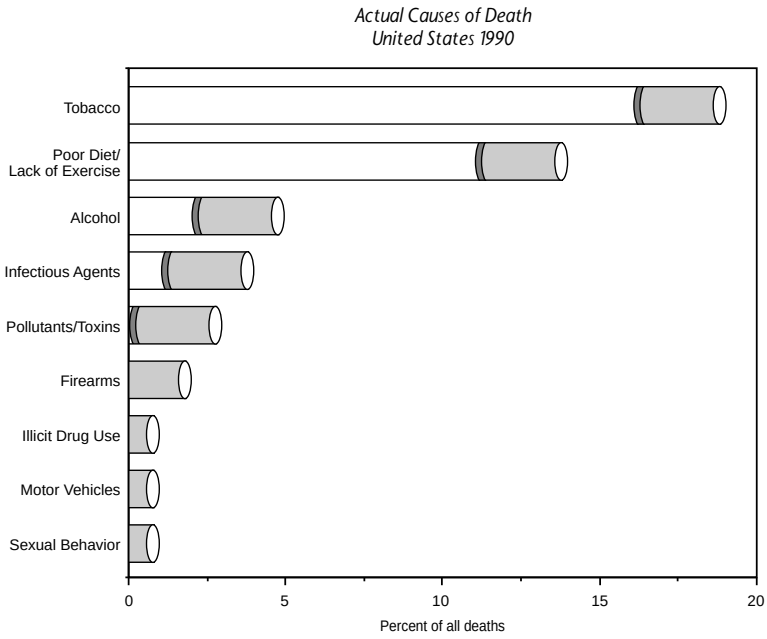
The Attorney General requested the Task Force to develop recommendations for a comprehensive, long term tobacco prevention and control plan in anticipation of a settlement or a favorable verdict in the state's litigation against the tobacco industry. The Task Force was asked to develop recommendations and strategies for (1) tobacco use prevention throughout schools and communities, (2) effective cessation programs, (3) public education campaign, and (4) limiting youth access to tobacco products. Research in tobacco prevention shows that in order to effectively reduce youth access and consumption of tobacco products, Washington state must develop and sustain a comprehensive long term plan.

The Task Force held its first meeting on May 12, 1998. The full Task Force met on July 9, August 17, September 14 and October 22, 1998. Recognizing that there is no single solution to prevent tobacco use by youth, the Attorney General requested that the Task Force recommend a multi-faceted, comprehensive approach. In response, the Task Force addressed the following subject areas: prevention, public education, schools, communities, cessation, youth access, high risk populations, research and evaluation, and additional policy considerations.

Various work groups met on numerous occasions throughout the summer months in person and by conference calls. The work groups consulted with community groups, private businesses, law enforcement and other states to seek their advice and learn from their experiences. This report was delivered to the Attorney General in November 1998.

Executive Summary

Resolution of the State of Washington's tobacco litigation will allow Washington state a unique opportunity to address the leading preventable cause of death in America – tobacco use. By coming together and developing a comprehensive strategy to deal with this problem, we can make a difference in reducing the number of adults who use tobacco and the number of our youth who begin to use this deadly product.



Source: McGinnis JM, Foege WH, Actual Causes of Death in the U.S., JAMA, 1993

Tobacco kills more than 400,000 people in the United States each year - the single largest killer in our society. We know that once people start to use tobacco, they become addicted to nicotine which makes quitting tobacco generally difficult. We also know that most of the people who begin using tobacco are children. That's why tobacco use has been labeled as a pediatric onset disease. Once a child begins to use tobacco, a life-long addiction is underway which often leads to disease. If we are to reduce the human and economic toll tobacco has exacted on our lives — we must reach our children now through a comprehensive, integrated and sustained approach to tobacco prevention and control.

In many instances ethnic communities of color, low income and blue-collar populations continue to have disproportionately higher rates of tobacco use. In order to effectively reduce tobacco use, we must address the needs of these populations in our programs.

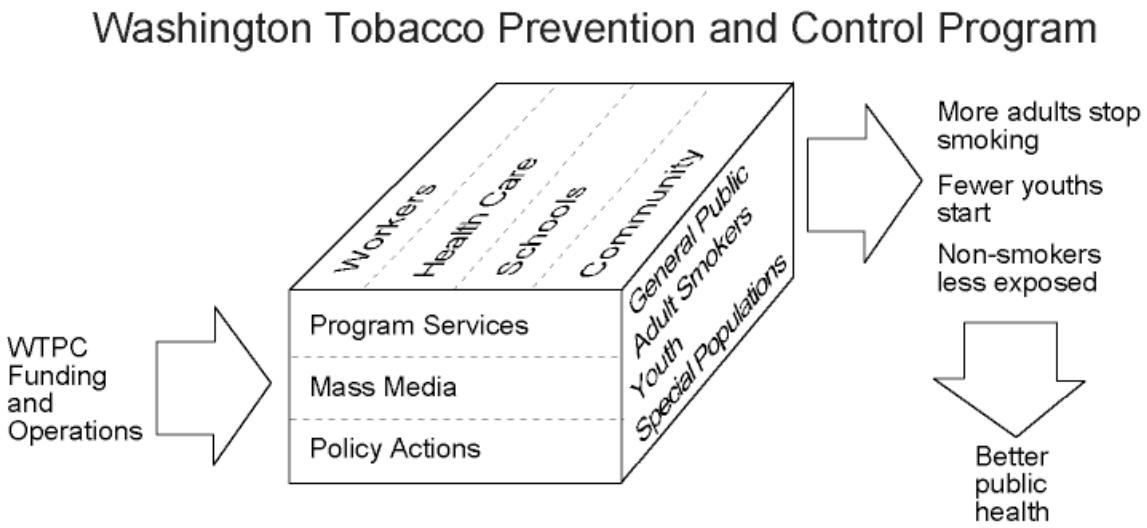
As a result of the tobacco litigation brought by Washington's Attorney General and many other states, we now have proof that tobacco companies targeted our children to replace users who have died or quit. Tobacco companies have used powerful imagery and specially designed marketing programs to permeate our society with images for our children to see and wear.

In May 1998, the Attorney General convened the Tobacco Task Force. The Attorney General asked the Task Force to develop a comprehensive, multi-faceted program that will first and foremost make a difference in the fight to keep tobacco products out of the hands of our children. The Task Force drew upon not only its own expertise, but on the expertise of the Centers for Disease Control and Prevention, the Food & Drug Administration, the Surgeon General, and other states to devise a program with three goals - the reduction of tobacco use by our children, a public education campaign to tell the truth about tobacco and the health consequences associated with its use, and cessation programs that can work effectively for those who want to stop using tobacco products.

The Task Force recommendations include:

- Establishment of a statewide oversight committee made up of a public-private partnership reflective of the diversity within Washington to advise and assist state and local agencies in finding and implementing the most effective programs to combat tobacco use and to develop prevention programs
- Improvement of our school-based programs so that our children receive accurate information and intervention regarding tobacco use on a regular basis
- Guaranteed access to reputable and effective cessation programs for Washington state citizens, including our children
- Reduction of access to tobacco products by our children by continuing strong enforcement efforts and strengthening our laws
- Expansion of community-based programs throughout the state to offer a variety of services and interventions to prevent and combat tobacco use particularly by our children
- Implementation of an effective public education and awareness campaign that will counter the onslaught of pro tobacco messages directed at our children, women and culturally and economically diverse populations
- Evaluation of our programs on a regular basis to ensure we have the best and most effective programs, and development of research into tobacco control and prevention issues
- Description of additional policy changes that need review in the future

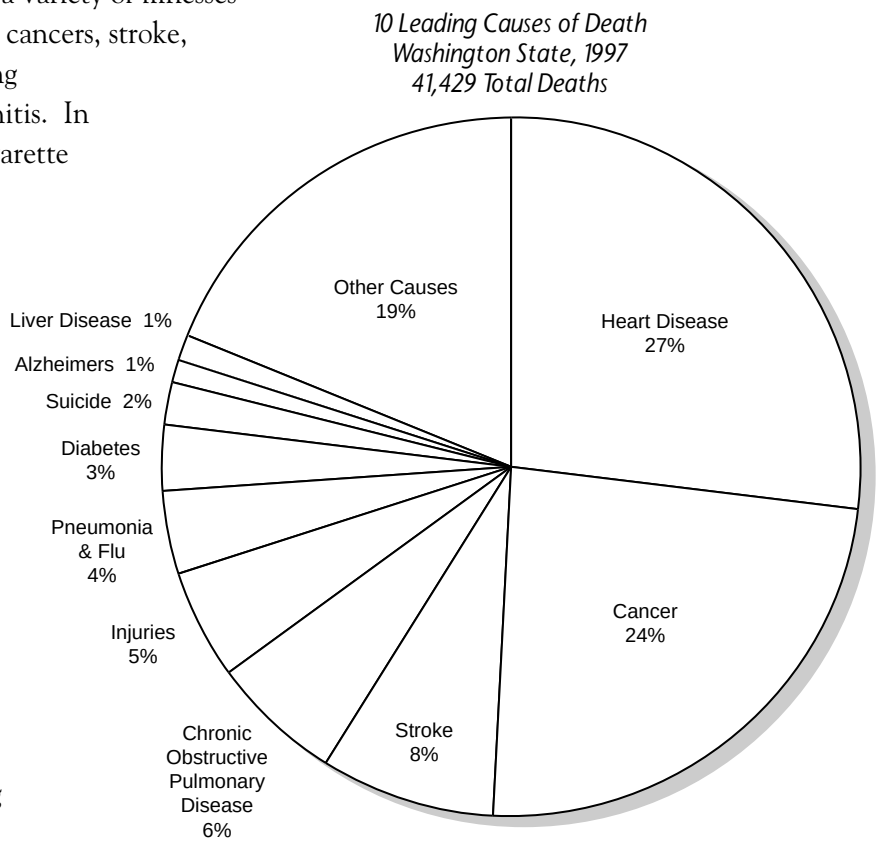
We know from our past efforts that none of the programs described in this report can work in isolation if we are to reduce tobacco use by children to the lowest possible level. We have developed a comprehensive approach designed to make tobacco use less acceptable, to prevent a lifetime of addiction, and to help those already addicted to tobacco products. We know after years of single program approaches that a comprehensive and sustained approach is the only way to effectively reach our youth.



The lawsuit brought by the Attorney General on behalf of Washington citizens will hopefully result in a substantial amount of money being brought to our state. The first priority for money received from a settlement or judgment should be the establishment of a comprehensive and sustained tobacco control plan. Following that, funds should be dedicated to public health purposes; e.g. the Basic Health Plan or other public health programs. Because the overall amount of money received by this state through a settlement or judgment is unknown, the Tobacco Task Force relied on the Centers for Disease Control and Prevention (CDC) formulas and estimates for tobacco control programs. The CDC ranges are guidelines based on the experiences of California and Massachusetts, and other states that have settled their lawsuits against the tobacco companies. The ranges are not necessarily based on amounts required for a comprehensive, sustained tobacco control plan. Further, the Tobacco Task Force understands that each recommendation's funding requirements may fluctuate from year-to-year as the comprehensive plan is implemented since staging some of the implementation may be necessary. The Tobacco Task Force looks forward to working with lawmakers to ensure a coordinated effort at improving the health of all of Washington state's citizens. We have an historic opportunity to use money we receive to reduce the disease and death caused by tobacco use.

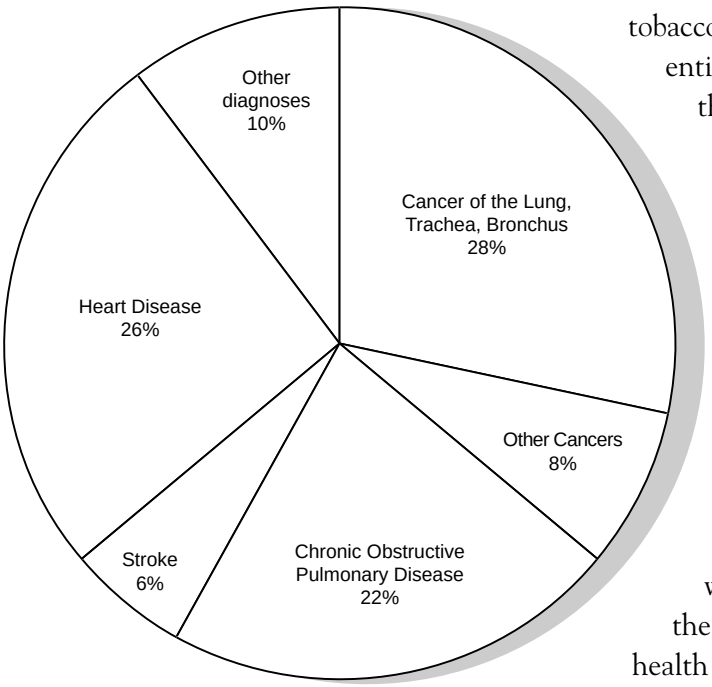
Statement Of The Problem

Tobacco use is deadly. More than 400,000 Americans die every year from tobacco- related illnesses. Tobacco is responsible for one out every five deaths and claims more lives annually than AIDS, alcohol, drug abuse, car crashes, murders, suicides, and fires combined. At least one out of every four cigarette smokers dies of smoking-related diseases. In Washington, tobacco related diseases cause more than 8,000 premature deaths annually from a variety of illnesses such as: cardiovascular diseases, cancers, stroke, and respiratory illnesses including emphysema, asthma, and bronchitis. In ethnic communities of color, cigarette smoking is a major cause of disease and death, with African Americans bearing the greatest burden.[1] Lung cancer is the leading cause of death in these populations. Health statistics also show that many more people die from exposure to environmental tobacco smoke, fires caused by cigarettes, and increased infant mortality due to low birth weight from maternal smoking.[2] Finally, the suffering of patients and families resulting from tobacco related diseases is unquantifiable.



Source: DOH, Center for Health Statistics, Death Records, 1997

Smoking Attributable Deaths
Washington State, 1997
8,202 Total Deaths



Source: SAMMEC (Version 3.0) Estimates prepared by DOH Office of Epidemiology, 1997

Tobacco use is expensive. In addition to the human toll, lost productivity, health care expenditures from tobacco-related diseases, and other economic costs of tobacco use amount to an unacceptable burden on entities in Washington state. As a government, the State of Washington expends substantial sums of taxpayer dollars for the increased cost of providing health care services for treatment of tobacco-caused diseases. Some examples include: Medicaid payments for medical services to the working poor and indigent, increased health care premiums for public employees and their families, and inflated industrial insurance premiums and depleted trust funds because of work-related illnesses due to tobacco use by some workers. In the private sector, companies and their employees also pay more for increased health premiums, affecting the economic climate in our state.

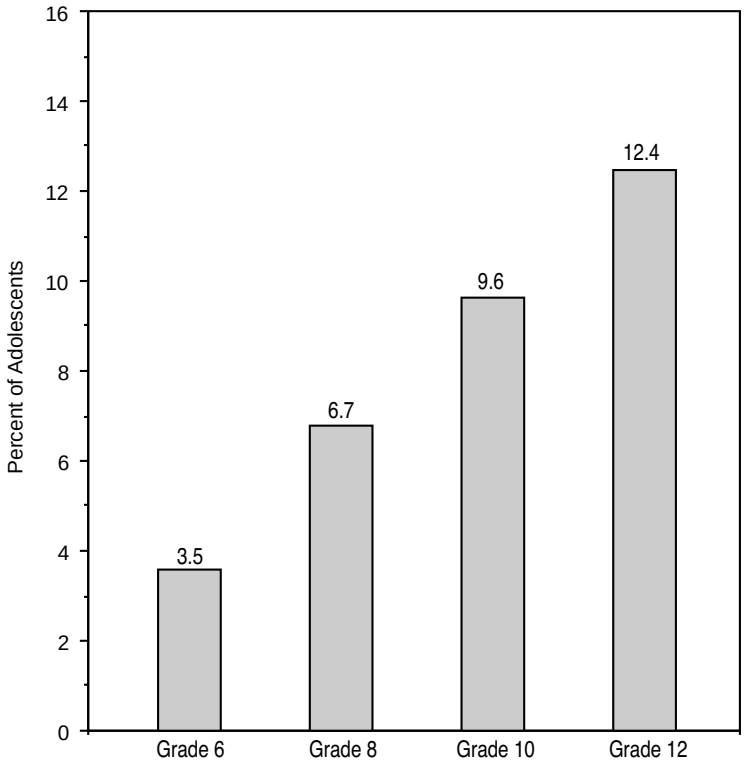
According to the Centers for Disease Control and Prevention (CDC), the cost of increased health care to Washington's taxpayers is enormous. The CDC estimates the state spends $705 million annually in increased medical costs alone. Recent studies estimate the direct cost nationwide is nearly $75 billion. In addition, these costs have been spiraling upward, more than doubling between 1987-1993. According to the CDC calculation, the present value of Washington's Medicaid only expenses attributable to smoking between 1980-1993 exceeds $1.154 billion. In Washington state's tobacco litigation, smoking attributable costs were analyzed by a damages expert at $2.2 billion for 1970 -1989.

Tobacco use is addictive. The *1988 Surgeon General's Report* concluded that tobacco products are addictive, that most tobacco consumers use tobacco regularly because they are addicted to nicotine, and that most tobacco consumers have a difficult time quitting tobacco because of the addictive nature of nicotine. Most smokers begin smoking during adolescence, and nicotine addiction begins during the first years of tobacco use.[3] Each year decisions by more than one million youths to become regular smokers commit the health care system to $8.3 billion in extra medical expenditures over their lifetime. [4] Thus, tobacco addiction is a disease that begins in childhood. In its regulations to restrict sales of tobacco products to protect children and adolescents, the Food & Drug Administration described tobacco use as a pediatric onset disease because the average age for the onset of tobacco addiction is 14 years old.[5] Approximately 80 percent of smokers begin before they are even legally able to smoke. If our youth can be prevented from starting before they are 18 years old, decades of research shows that they will probably never start. Thus, the decision by a young adult to use tobacco has lifetime consequences - for the individual and for society.

Tobacco use strikes children: One of the most disturbing trends is the growing ranks of young people that are starting tobacco use. In April, the Centers for Disease Control and Prevention released alarming new national data regarding teen smoking and its dramatic rise in the 1990's. Nationally, over the last six years, youth smoking has increased by one-third. Nearly half (48 percent) of all high school boys and more than a third (36 percent) of all girls had reported using tobacco products in the past month. Teen tobacco use has increased among young people of all races and ethnicities but has skyrocketed in minority communities – an astounding 80 percent by African American youth.[6]

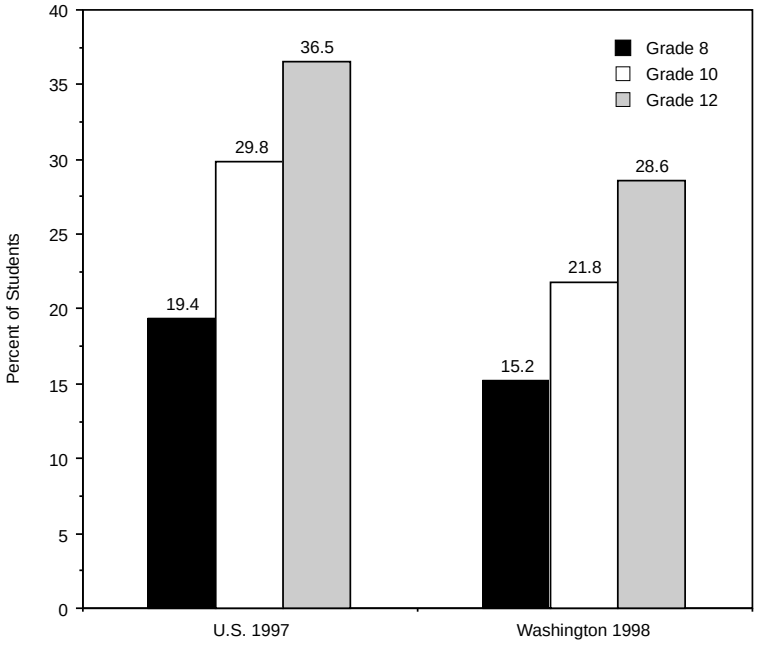
In Washington state, approximately 300,000 youth smoke cigarettes and an additional 110,000 use smokeless tobacco. In Washington, minors consume at least 516 million packs of cigarettes per year and at least half of those are illegally purchased by minors. In other words, approximately one third of Washington youth under age 18 use tobacco. According to the *1998 Washington State Survey of Adolescent Health Behaviors*, nearly one of every eight high school students smokes at least five cigarettes per day. In Washington, lifetime prevalence rates of smoking has increased steadily among students since 1990. Today, one in four Washington sixth grade students has already experimented with cigarettes. By the end of high school, two out of every three Washington students have tried smoking and 42 percent of them are regular smokers.[7] One out of three youths who start using tobacco regularly will die from their tobacco use.[8]

Smokeless Tobacco Use Among Adolescents
Use During the past 30 days - Washington 1998



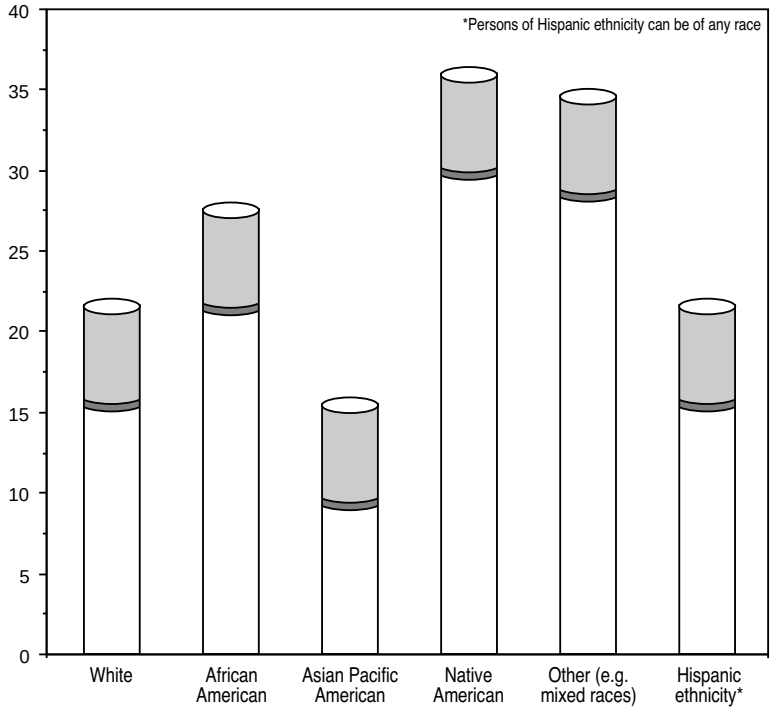
Source: Office of the Superintendent of Public Instruction, Survey of Adolescent Health Behaviors, 1998

Cigarette Smoking Among Adolescents - U.S. and Washington
Use During the Past 30 Days



Source: U.S. Data, Monitoring the Future Project, University of Michigan, 1997; Washington Data, Office of the Superintendent of Public Instruction, Survey of Adolescent Health Behaviors, 1998

Adults Who Smoke by Race in Washington State 1993-1997
(Weighted Percent)

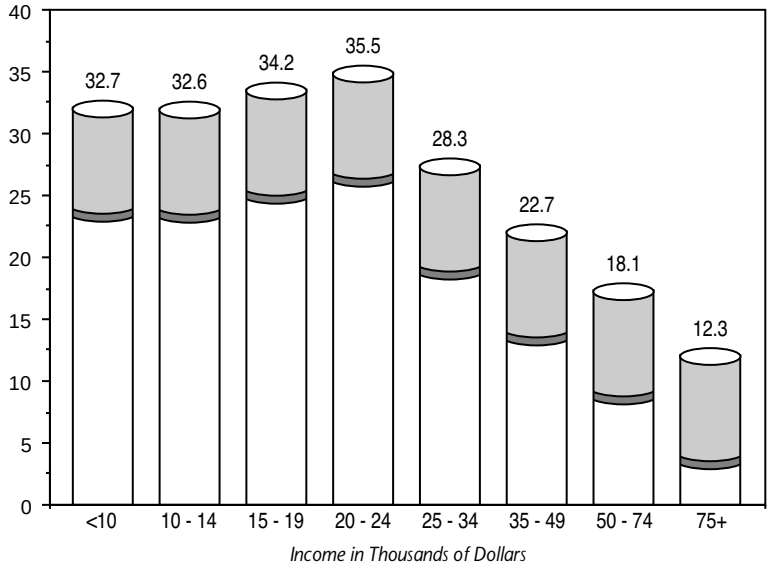


Source: DOH BACS, 1993-1997; DOH, Center for Health Statistics, Behavioral Risk Factor Survey, 1993-1997

Tobacco use strikes different groups disproportionately. A comprehensive plan to reduce tobacco use must address the multi-cultural and special needs of Washington's diverse population. Tobacco control programs traditionally have served the mainstream population. However, research shows that tobacco use varies significantly between different segments of our state population. According to the Centers for Disease Control and Prevention, 23.7 percent of the adult population smoked regularly in 1997. However, the tobacco prevalence rates are strikingly greater for ethnic communities of color, people of low-income, blue-collar workers, young adults, the gay and lesbian community and other at-risk groups.

The 1998 Report of the Surgeon General entitled *Tobacco Use Among US Racial/Ethnic Minority Groups*, addressed tobacco use among the African American, American Indian and Alaska Native, Asian Americans and Pacific Islanders and Hispanic communities. The Surgeon General concluded that cigarette smoking is a major cause of disease and death in each of the four population groups studied in the report. After several years of substantial decline, adolescent smoking dramatically increased in the 1990's among African Americans and Hispanics.

Who Smokes Cigarettes in Washington
Percent of Adults by Income Level, 1997



Source: DOH, Center for Health Statistics, Behavioral Risk Factor Survey, 1997

Smoking prevalence is also disproportionately higher in other specific communities. Although there is conflicting data on smoking among gay men, data from several sources suggest that the smoking prevalence of gay men is somewhat greater than the general population. The pressures that result in teenage smoking are compounded for gays and lesbians struggling with their sexuality.[9] Blue collar workers and their families smoke at a rate that is

more than twice the average rate in the United States and almost four times as much as in white-collar populations. We know that children of smokers are more likely to smoke and young people who seek or are recruited into blue collar occupations are more likely to be smokers than those who seek other careers.[10] Therefore, it makes good sense to reduce the prevalence among adult blue-collar workers to ultimately reach their children as well.[11]

Tobacco use is preventable. The Centers for Disease Control and Prevention cites tobacco use as the "single most important preventable cause of death in our society." [12] A comprehensive tobacco control approach is key to changing the rates of tobacco addiction. Research has shown that when states spend more money to educate the public about the dangers of tobacco and to make prevention and cessation services readily available, tobacco addiction rates fall faster than the national norms.[13] The key is not only a comprehensive program, but a program that is sustained over time.

Several states have already implemented comprehensive, long-term tobacco control programs. These include California, which passed a dedicated tax in 1989, Massachusetts, which passed a similar tax in 1992, Arizona in 1994, Oregon in 1996, and Alaska in 1997. Thus far, California and Massachusetts are the only two state programs that have had programs in place long enough to measure outcomes. Studies of these state programs show that dedicated funds coupled with comprehensive tobacco control plans have resulted in:

- Significant reductions in adult tobacco use
- Prevention of increases in youth tobacco use despite rising national rates
- Increased numbers of communities working to reduce and restrict tobacco use and reduce exposure to environmental tobacco smoke since environmental tobacco smoke has been linked to pediatric diseases such as asthma, bronchial infections, and ear infections

For example, in fiscal year 1997, California spent $131 million per year[14] for comprehensive tobacco control programs. From 1990 -1993, the first three years of its program, cigarette consumption fell by more than 40 percent. Over 4.2 million school children received tobacco use prevention education. Youth smoking rates in California gradually declined from 11.9 percent in 1995 to 10.9 percent in 1997, while national rates for tobacco use increased. According to a recent study in the Journal of the American Medical Association,[15] California's initial efforts in 1993 did not continue due to conflicts about funding and increased tobacco company advertising expenditures, thus slowing its initial highly successful reduction rates.

Since 1992, Massachusetts tobacco consumption decreased in that state 31 percent – three times the national average. Adult consumption dropped from 20 cigarettes a day to 14 cigarettes a day, with more people trying to quit. Youth consumption of tobacco remained flat, while the national numbers skyrocketed. The number of local ordinances restricting indoor smoking increased throughout the state. As far as program expenditures, in fiscal year 1997, Massachusetts spent
$36 million.[16]

In Florida, a pilot program will expend $100 million per year for at least two years[17] as a result of their tobacco litigation settlement. The program will include a counter-advertising campaign to reach at least 95 percent of Florida's youth, funding for all county school districts to train teachers in youth tobacco cessation, and a network to increase the number of initiatives developed for African Americans, Hispanics, Native American, and ethnic communities of color.

Over the last decade, Washington has made efforts at reducing youth access to, and consumption of, tobacco. Currently Washington's tobacco tax is the 3rd highest in the nation at 82.5 cents per pack.* However, none of Washington's taxes go to tobacco prevention or cessation efforts. The Washington State Liquor Control Board and local health departments have worked hard to bring retailers into compliance with Washington's Tobacco-Access to Minors statute (RCW 70.155) which prohibits the sale of tobacco products to minors, and provides penalties for retailers who violate this prohibition. At the time of passage of Washington's Tobacco-Access to Minors law in 1993, non-compliance rates for retailers were estimated at 60 percent. By 1997, those numbers had declined to 5.5 percent. The Department of Health has developed or participated in a variety of programs, some lasting only one or two years, designed to address youth and tobacco use. These efforts are steps in the right direction. They have kept youth tobacco use from increasing in Washington State at the national rate. But, we still have seen an increase in tobacco use since the early 1990's and we must do more to prevent this trend.

Our efforts pale when placed alongside the tobacco industry's efforts to reach our children. The industry spends over $100 million annually on advertising in Washington state alone. Nationally, the industry spends $ 5.1 billion on advertising and marketing. As we learned from the state's litigation, tobacco companies deliberately target our children because, in their words, they need replacements for those users who die or quit. We must expend the resources necessary to combat this powerful force.

The money designated for our state from the tobacco litigation gives Washington an opportunity to put all the elements necessary for successful reduction in youth tobacco use into place at one time in a coordinated fashion. The key to cutting the human and economic toll of tobacco lies in our efforts to reach our children and to help adults quit. Resources applied to tobacco prevention and cessation now will gain us future savings both financially and socially. We must commit now to a comprehensive, integrated long-term program. Keeping our youth tobacco free must be a top priority for Washington state.

**Alaska & Hawaii are tied with the highest tax at $1.00*

Task Force Recommendations

Just as the cause of tobacco addiction is complex, so are the public health approaches to the problem. There is no silver bullet. The best approach requires a comprehensive, integrated program and a long-term commitment. Our program in Washington state should complement any work that may be done as a result of a multi-state settlement. We must develop a program specific to our state that will recognize the diversity of Washington's population and its regional differences. The program should include an emphasis on the needs of populations that have been disproportionately affected by tobacco use and target them: pregnant women, ethnic communities of color, blue collar, and people of low-income. Most importantly, the program must place a special emphasis on children and teenagers since nearly 80 percent of smokers start before they are 18 years old. Science, common sense, and our collective conscience tell us to start with youth.

With Washington poised to receive substantial revenue as a result of the state's litigation against the tobacco industry, we have an historic opportunity to dedicate dollars to the public health goal of a significant reduction of the most preventable cause of death in our society — the use of tobacco.

How Do We Combat Tobacco Use in Washington?

Based on extensive research and review of what is working in other states, the Task Force recommends the following:

- Establish a statewide oversight group reflective of the diversity of Washington state
- Improve school-based programs
- Guarantee access to reputable cessation programs
- Reduce access to tobacco products by minors
- Expand community-based programs
- Implement a public education and awareness campaign designed to reach a diverse population
- Evaluate programs on a regular basis and conduct research into the most effective programs regarding tobacco use and prevention
- Develop additional policy changes important to a comprehensive and sustained tobacco control plan

Recommendation No. 1: Establish a Statewide Oversight Committee.

The Attorney General's Tobacco Task Force recommends that a statewide oversight committee be established to review, monitor and advise the Department of Health, the Office of the Superintendent of Public Instruction, the Liquor Control Board and the Department of Social and Health Services on effective tobacco prevention and control initiatives to be funded out of the proceeds received through a settlement or verdict in the state's lawsuit against the tobacco industry. This oversight committee shall be known as the Washington Tobacco Prevention & Control Partnership.

The Attorney General's Tobacco Task Force recommends that the Department of Health be the recipient of monies appropriated by the legislature for tobacco control and prevention from any settlement or verdict. Furthermore, the Task Force recommends that inter-agency agreements should be used to identify the responsibilities of the other state agencies and to transfer the funds to carry out these tasks. The Department of Health, in partnership with the oversight committee, should be the central coordinator for state government's tobacco prevention and control initiatives.

The purpose of the Partnership is to exercise oversight over the implementation of the recommendations contained in the *Attorney General's Tobacco Task Force Report*. The Partnership will review, monitor and comment on the effectiveness of the implementation of the report's recommendations. Particular emphasis will be placed on research and evaluation of program effectiveness. The Partnership may establish advisory committees as needed to provide input on tobacco control initiatives. The Partnership shall establish a statewide youth advisory committee.

Each state agency will develop work plans to carry out the recommendations in the report. These work plans along with periodic updates and an annual year end report shall be provided to the Partnership. The Partnership will monitor and comment on these activities and report annually to the Governor, Attorney General and the Legislature on the successes and lessons learned.

The Partnership will coordinate efforts to achieve compliance with any multi-state settlement and state initiatives in order to maximize resources and the effectiveness of tobacco control and prevention programs. The Attorney General will be responsible for enforcing compliance of any settlement document. The Partnership will be pivotal in monitoring these activities to ensure coordination.

The partnership will work with any national efforts which may be established if a settlement is achieved. It will be up to the Governor and the Legislature to allocate the proceeds received from any settlement or judgment to those purposes consistent with the basis on which the litigation was brought. The Partnership's oversight responsibilities will ensure accountability to the Legislature as to the effectiveness of tobacco control and prevention programs. The Partnership will be a strong voice for community input and involvement. The Partnership will coordinate communication between governmental and non-governmental entities. It will be the embodiment of a true partnership between the public and private sectors.

The Task Force recommends that the state's Partnership be initially chaired by the Attorney General. The Task Force recommends that the composition of the Partnership membership shall be as follows:

- Chaired by the Attorney General for the first two years
- Three appointees by the Governor (one policy person and two community representatives)
- Four Legislative members, one from each caucus in each House
- Two members from the Department of Health
- One member from the Division of Alcohol and Substance Abuse
- Six community representatives appointed by the Department of Health
- One Tribal Representative appointed by the Governor
- Two at large positions representative of at-risk populations appointed by the Governor

The Attorney General's Tobacco Task Force recommends that membership on the Partnership be limited to no more than 20 members.

The Health Science Analysis Project[18] has studied the components of successful tobacco control programs and has identified seven guiding principles. The Attorney General's Tobacco Task Force recommends that the administration of a successful tobacco control program include the following seven principles:

- Have the capability to coordinate multiple strategies at national, state and community levels
- Involve a wide range of public health stakeholders
- Adopt programs and polices that are based on proven public health strategies
- Prohibit tobacco industry involvement in overseeing a tobacco control program
- Encourage advocacy by state and local organizations and communities
- Provide stable, long-term funding
- Eliminate state preemption of local governmental activities relative to tobacco control

What would it cost?

Start-up staff support during initial organization shall be provided by the Department of Health. The Center for Disease Control & Prevention (CDC) recommends 5 percent of the total dollars of the tobacco control plan annually as the figure needed to administer and manage the plan. Using the CDC figures as a guide, funding for the Partnership shall be 5 percent of the total dollars appropriated by a settlement or judgment proceeds for the tobacco prevention and control efforts, or $2.25 million annually. This amount is based on the figures recommended in this report.

Total Annual Budget for Recommendation 1: $2.25 million

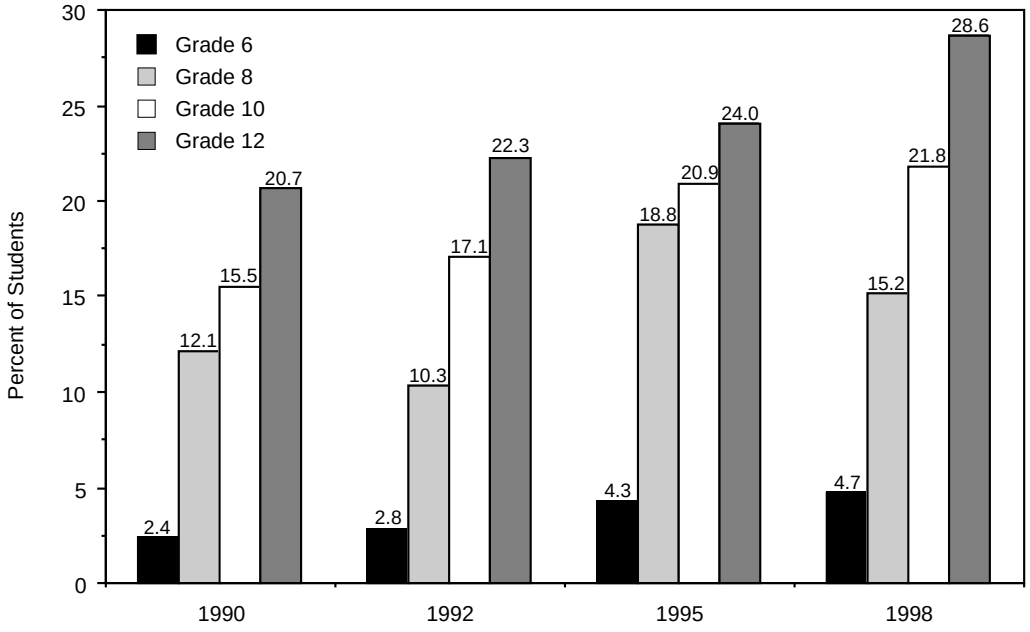
Total Biennial Budget for Recommendation 1: $4.50 million

Recommendation No. 2: Improve School-Based Tobacco Programs to Impact the Largest Percentage of our Youth.

The second recommendation in our comprehensive plan centers on increasing programs at our local schools and encouraging schools, parents and communities to work to together to create sustained programs.

Schools are one of the most important places where the majority of youth can be reached since children spend significant hours in school settings over the course of many years. This ready access to young people encourages us to place more prevention efforts into the school environment. In addition, schools provide a variety of settings to reach young people. Traditional health education classes provide an opportunity to learn about the health issues surrounding tobacco use. Less traditional settings such as science, physical education, and mathematics provide exciting complements to traditional classes. For example, students can learn about tobacco by studying nicotine in chemistry courses. School sports programs can set a no-tolerance policy toward tobacco use, requiring abstinence as a condition for sports

Trends in Cigarette Smoking Among Adolescents
Use During the Past 30 Days - Washington State 1990-1998



Source: Office of the Superintendent of Public Instruction,
Survey of Adolescent Health Behaviors, 1998

participation, and can give our youth information on tobacco's effect on sports performance. Social studies classes can study tobacco use as an acceptable social norm and how such a deadly product came to be viewed by society in that manner.

Based on numerous independent studies, California school-based tobacco prevention education programs that focus on skills training approaches have proven effective in reducing the onset of smoking. The Centers for Disease Control and Prevention have curricula and guidelines that are available for use in schools, including a focus on cessation programs for youth already addicted to nicotine. Washington should join those states with an effective school program aimed at prevention and seek out the most effective programs for school-based interventions.

What works in other states?

The following are examples of school-based tobacco prevention programs:

California The California Department of Education manages the Tobacco-Use Prevention Education (TUPE) program that provides funding through an application process. This funding is for tobacco-specific student instruction, reinforcement activities, special events, and cessation programs for students. Eligibility is limited to school districts that have a fully implemented tobacco-free school district policy. Programs in grades four through eight are funded through an entitlement program at seven dollars per child based on average daily attendance, while programs in grades nine through twelve are funded through a competitive grant process at $25 per youth based on average daily attendance. County offices receive a minimum of $25,000 and a maximum of $150,000 to provide training and technical assistance. California competitively awards $1-2 million per year for innovative approaches to

school-based tobacco prevention. All funded programs are locally developed, but are expected to align with the Centers for Disease Control and Prevention Guidelines for School Health Programs to Prevent Tobacco Use and Addiction, along with the Health Framework for California Public Schools.

Massachusetts Massachusetts approaches tobacco prevention through comprehensive school health education. Annually, approximately $28 million of the tobacco excise tax is directed to the Department of Education for comprehensive school health education. This amounts to around $28 per public school student (pre-kindergarten through 12th grade).

This comprehensive approach includes the following content areas: community health, disease prevention and control, environmental health, family life, healthy relationships, mental and emotional health, nutrition, personal health, personal safety, physical activity and fitness, resource management, sexuality, and tobacco, alcohol and other drug use. In addition, the Massachusetts Department of Public Health awards $5-6 million annually to schools to support school-based health clinics.

Training for teachers is a significant priority, along with assessment and evaluation of tobacco-use prevention programs on a regular basis. Cessation for students and staff is also an allowable activity. The program encourages the involvement of parents and the community in support of the school-based programs. Because each school is autonomous and may approach the problem in different ways, there is some question as to whether school-based prevention is making a difference in Massachusetts according to Massachusetts Tobacco Control Program staff.

The status in Washington With the passage of the Washington Education Reform Act (ESHB 1209) in 1993, Washington state established common learning goals for all Washington students to raise academic standards and student achievement. The Commission on Student Learning subsequently approved a set of Essential Academic Learning Requirements (EALRs) which defined the specific academic skills and knowledge the state's students will be required to meet. The EALRs in health and fitness "establish the concepts and skills necessary for safe and healthy living, and in turn, for successful learning." Another of the EALR's requires that students understand the consequences of tobacco use (and alcohol and other drugs) and to develop the skills necessary to resist use. Integration of tobacco prevention education into the overall education reform effort fits the goals of the Education Reform Act.

Washington state youth are targeted constantly by media and fed a steady diet of ideas about sex, violence, or tobacco use that does not always agree with society's values or ethics. Our children are targeted by slick marketing campaigns. The tobacco industry's "Joe Camel" campaign is an excellent example of the effect of these campaigns. Since the inception of "Joe Camel" in 1988, Camel sales to those under 18 years old are estimated to have increased from six million to more than $476 million annually.[19] Our society is saturated with images that glamorize not only nicotine addiction, but also violence and consumerism.

In conjunction with Washington's new learning goals, our state must develop a "Media Literacy" program for students to help our youth become critical thinkers regarding their environment, and especially the images they see. Media literacy shows students how to critically review an advertising

message that has been carefully developed to sell a certain idea or product to youth. By learning to view advertisements and other images with a critical eye our children are better able to make independent decisions about behaviors such as tobacco use. Media literacy allows youth to be on a more even playing field with advertisers.

During the 1997-98 school year, there were 296 operating school districts with a total of 991,235 enrolled students. School district size ranges from a low of 9 (Benge) to a high of 47,883 (Seattle). There were 538,891 students (54.37 percent) enrolled in the 30 largest districts, each with over 10,000 students. Three-fourths of students are in Western Washington with most in the four county Puget Sound metropolitan areas (King, Kitsap, Pierce and Snohomish). One-fourth of students are in Eastern Washington, with half of these enrolled in Spokane and Yakima counties.

Washington schools currently receive $4 per capita through the Superintendent of Public Instruction's (OSPI) Safe and Drug Free Schools Program. This small amount of money is intended to address all alcohol, drug , tobacco and safety issues. These funds can be used for a variety of purposes that range from prevention to security. Although funds may be used for purchasing tobacco prevention curricula and training, given the demands on the funds, we know that insufficient dollars are allocated to tobacco prevention.

Funds from Washington's Youth Tobacco Prevention Account are allocated to local health jurisdictions and can be used to purchase tobacco prevention and education curricula. Many of these agencies have acquired and disseminated materials to schools. However, due to significant cost, most have not purchased curricula recommended by the Centers for Disease Control and Prevention. In addition, the Centers for Disease Control have already studied and developed characteristics of effective school based programs which are reflected in our recommendations in this report.

Peer education has been used in some counties to prevent tobacco use. Programs such as the Americans for Nonsmokers Rights Foundation's Teens as Teachers Program and the Teens Against Tobacco Use program have been implemented in most King County school districts through the efforts of the Seattle-King County Department of Public Health. Likewise, other local health agencies have coordinated and facilitated peer education in schools. Training opportunities for youth and teachers have been made available, but the impact has been relatively small due to budget constraints and lack of school commitment in some communities. This type of innovative program should be examined as we develop our comprehensive and multi-faceted approach to reduction of tobacco use by youth.

Recommendations

Funding our State's public schools needs to be increased in order to have an effective and comprehensive approach to tobacco use prevention. Dedicated funding is also necessary for tobacco prevention programs. Use of a dollar amount per child would allow for calculation of the funding. A phase-in application process should be utilized so that school districts that are ready to implement tobacco programs are funded in the first round of applications. Likewise, implementation and planning grants would be available to districts that are not yet ready to implement programs. Eventually, all school districts in the state would receive program funding. The goal is to ultimately reach all children in the state. OSPI should develop criteria for programs and grants, including funding. School districts partnering with other community organizations should be eligible for increased funding and schools

should coordinate with local health departments. OSPI should be allocated an amount for administrative costs, including the cost of preparation of a biennial report to describe and evaluate the funded programs. OSPI should also be responsible for conducting statewide training. School-based programs in Washington at a minimum would:

- Develop and enforce tobacco-free school policies
- Provide K-12 instruction, with special emphasis on middle schools, about short and long-term negative physiological and social consequences of tobacco use, social influences, peer norms, media literacy, and refusal skills
- Support school-based cessation programs, and encourage partnerships with existing community-based cessation programs, for all students and staff who want to quit
- Provide tobacco prevention curricula and training for teachers
- Develop appropriate programs for culturally diverse students
- Integrate tobacco prevention into the Essential Academic Learning Requirements
- Involve parents and families in support of the programs
- Work in conjunction with the public education, community, and cessation programs
- Work in partnership with local health departments and other community based programs
- A comprehensive assessment of tobacco prevention in schools should be conducted as a first step in developing school-based programs

What would it cost?

$5.00 per student should be allocated by the Legislature for school-based programs. At $5.00 per student, funding of $4,956,175 would be generated. The Centers for Disease Control & Prevention recommend a range of $4.7 million to $7.05 million (annually) be allocated for school-based programs. These figures are based on an amount for training and infrastructure and include a range of $4.00 to $6.00 per student. OSPI's administrative expenses will be capped at $250,000 including preparation of a program evaluation in the form of a biennial report. Statewide training of school personnel and other technical assistance would be provided by the Educational Service District, at $750,000 per year. Thus, the remaining amount of money available for the application process under this recommendation is approximately $3.96 million.

Total Annual Budget for Recommendation 2: $4.96 million

Total Biennial Budget for Recommendation 2: $9.92 million

Recommendation No. 3: Create Ready Access to State of the Art Cessation Programs for Washington Citizens with Special Emphasis on Youth.

A primary goal of any comprehensive tobacco control plan is to encourage and assist both youth and adult smokers to quit using tobacco. Therefore it is essential to provide access to cessation services for both youth and adult smokers as our third recommendation outlines.

To have a real impact on tobacco use cessation, we must target both youth and adult users. The fewer adults that use tobacco, the fewer smoking role models there will be for youth to pattern themselves after. For adult smokers, 89 percent began using cigarettes and 71 percent began smoking daily by or at age 18. Cessation programs that have proven effective with adults should be made easily available. Effective cessation programs that work for youth require further research and development.[20]

Youth Cessation

We know more about what works to help adults stop smoking than we do youth. There are many reasons for this. One reason is that few studies have been conducted on youth cessation of tobacco use.[21] Another reason is that smoking-related diseases usually manifest themselves in adulthood, and adults threatened by illness are usually more motivated to stop smoking.[22] In addition, adults are more capable of enduring delayed gratification and controlling impulses than youth. Research that has been completed provides some data and insight into the types of programs that are more likely to be effective with youth. Continued research is necessary to develop effective cessation programs for youth.

Among youth, peer influences, peer approval and social pressures are strongly associated with tobacco use and cessation. Parenting practices also influence whether children in the family smoke: lack of parent-child closeness, inconsistent discipline and ineffective monitoring have been associated with tobacco use.[23] When youth live in an environment in which others use tobacco, they are more likely to use tobacco and less likely to quit. Media influences also have a well-documented effect on tobacco use among youth with youth smoking the most heavily advertised brands. For instance, Marlboro, Camel, and Newport are the top three brand choices used by 86% of adolescents and they also are the most heavily advertised brands.[24] Internal tobacco industry documents discovered during the states' litigation against the industry revealed evidence that the industry targeted youth as future tobacco consumers.

The emphasis for youth cessation programs should be on program research, development and evaluation. Research should be conducted on the characteristics of youth smokers and the most promising available programs.

Pilot projects may be a useful evaluative tool. Partnerships with academic researchers should be encouraged. Activities that promote and facilitate access to information about available cessation services should be encouraged and funded. Program effectiveness can be measured in multiple ways including: 1) degree of change in knowledge and attitudes regarding the decision to use tobacco; 2) changes in belief and intent; 3) changes in smoking behavior (reduction and cessation); and 4) changes in other related behavior. The goal is to develop programs that increase the likelihood that motivated youth can successfully quit smoking.

Common problems with youth cessation programs:

- Insufficient research on youth tobacco cessation programs
- Difficulty recruiting youth to programs
- Difficulty keeping youth in programs when recruited
- Effects of peer influence
- Limited coping skills among young people increases risk of relapse
- Parent/family smoking influences
- Lack of parenting skills related to tobacco use
- Insufficient resources dedicated to youth cessation programs when compared with other youth treatment programs for addiction
- Highly effective and repetitive pro-tobacco messages from tobacco industry promotional activity

Youth cessation can be addressed in a variety of ways and in a number of different settings: classroom presentations on smoking and health, encounters with health care providers during physical exams or at school health clinics, self-help materials, referrals to existing community cessation programs and cessation programs within schools. Providing multiple options reaches a wider youth audience.

Although promising programs exist around the country, continued research and development is on youth cessation programs is necessary. The following recommendations outline components of programs that have been tried, that youth have responded to, whose content is judged by both youth and program leaders to be most relevant, and those strategies within specific settings (schools, health care clinics, treatment programs) that have facilitated more successful involvement of youth and staff[25]:

- Group counseling approach so that youth can establish a peer group and support system around tobacco cessation
- Support with nicotine replacement drugs or other medicines has been shown to be safe but has not yet been shown to be effective with youth. Further studies are necessary.
- Intervention services should be available in places or formats frequented by youth: schools; worksites; teen programs; the Internet; telephone help lines
- Focus on the long-term health risks associated with smoking is not a sufficient inducement to get adolescents to quit smoking. Focus instead on cost, social stigma, effects on athletic performance.
- Firm, unequivocal advice to quit smoking from health care providers
- Availability of smoking cessation training for school personnel, health care professionals and other professionals who regularly work with adolescents.
- Quit lines staffed with appropriately trained staff
- Maintain confidentiality of adolescents who participate. Youth often will not volunteer for cessation programs because they do not want their parents to know they smoke
- Combine both addiction-based content and psychosocial dependency content in cessation programs

- Emphasize the difference between what young people perceive about the smoking behavior of their peers (everybody uses tobacco) and what is actually happening (a minority do)
- Firm rules about not smoking on campus for students and faculty

A majority of adults who use tobacco express an interest in quitting. For youth who have used tobacco regularly for a period of time, this appears to also be true. While some youths have expressed an interest in quitting, many are not motivated to do so. While the strategies to assist adults and youth to quit may need to be different, there are some similarities worth mentioning:

All need barrier-free access to cessation programs. Access issues can include program funding, availability of transportation to get to the program, convenient clinic hours and locations and telephone assistance.

Both adults and adolescents need firm, repetitive counseling from health care providers to quit smoking.

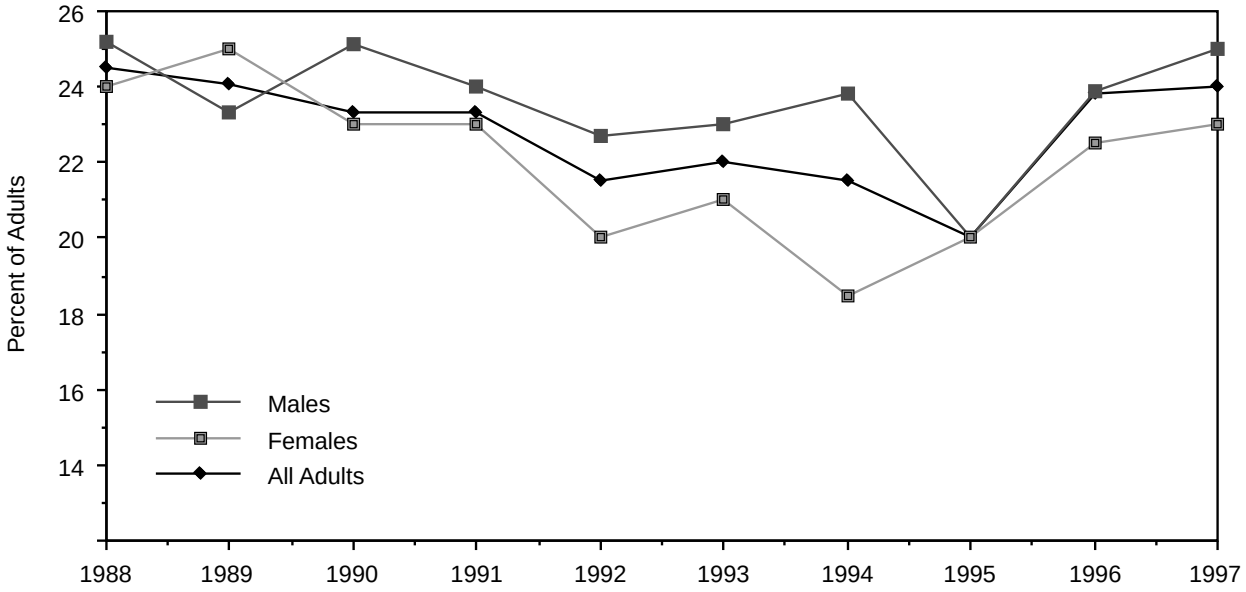
Adult Cessation

While more research is needed regarding some of the newer cessation strategies, we know that there are cessation programs for adults that work, especially as part of a comprehensive tobacco control policy. A successful tobacco cessation strategy for adults should employ several concurrent approaches:

- Effective programs must be available and easily accessible
- Nicotine patches and other medications that have been proven effective must be available when appropriate.
- Strong clean indoor air policies can help reinforce cessation, especially in youth
- Mandated full insurance coverage (both public and private) for cessation programs (for both adults and their children). Nicotine patches and other medications should be covered in conjunction with behavioral cessation support. However, these requirements should not result in barriers to access for tobacco users to get to the programs.
- Appropriate tobacco cessation education of health care providers must occur, including training in how to work effectively with tobacco users.
- Disseminate culturally and linguistically appropriate cessation materials and programs
- Special emphasis must be placed on targeting pregnant women with cessation efforts
- Statewide quit lines that provide proactive cessation counseling must be available to all that need them

Improvement in cessation support should be measured by the effectiveness of the programs, and the penetration into the population (impact). Experience with best practices indicates that up to ten percent of smokers will take part each year in organized cessation programs, if they are marketed strongly and if access barriers are removed.[26]

Prevalence of Smoking Among Washington Adults 1988-1997



Source: DOH, Center for Health Statistics, Behavioral Risk Factor Survey, 1988-1997

Program Evaluation & Research

Research and evaluation needs to be adequately funded. Research and development on cessation programs for youth and adults in Washington state should be coordinated with national organizations such as the National Cancer Institute, the Centers for Disease Control and Prevention and the Robert Wood Johnson Foundation as well as other states. New techniques that have not been subject to scientific scrutiny should be formally evaluated before being eligible for reimbursement.

Recommendations

To develop and implement an effective cessation program, the Task Force recommends:

- The private and public sectors need to work together to undertake a comprehensive, integrated approach toward tobacco cessation. A statewide program should encourage and support health care organizations, cessation service providers, employers and schools to ensure that all tobacco users — adult and youth —have barrier-free access to effective tobacco cessation resources. These programs, in turn, should address the special needs of youth, blue-collar workers and cultural minority populations, including language specific programs as appropriate.
- Health care providers should be trained to advise and counsel adults and youth to quit smoking. Incentives and tools should be provided to health care systems to identify the smoking status of all patients, give brief advice, and provide referrals for more intensive follow-up. Insurance reimbursement should cover such counseling. Individual grants should be available on a competitive basis to health plans, hospitals, practice associations, cessation providers, employers, community organizations, schools, and state and local governments to implement cessation programs. The grants could be awarded for training personnel to implement cessation programs including clinic based activities, staff support for planning and implementation of cessation

programs, purchase educational materials. The purposes for which the grants could be used should be consistent with the United States Agency for Health Care Policy and Research (AHCPR) cessation guidelines. Partnerships between different organizations should be encouraged. Some use of funds to off-set service delivery should be considered if the provider is in compliance with the AHCPR guidelines.

- Funds should be used to pay for some direct cessation services for certain populations such as the medically underinsured, basic health plan enrollees, and Medicaid recipients. Agencies responsible for the insurance products provided to these populations require tobacco cessation services as part of their usual coverage. Funds should also be used to encourage coverage and to relieve some of the burden on private health plans. It may be helpful to appoint an advisory group to develop and monitor mechanisms that will maximize the effectiveness of funds spent on cessation.
- A toll-free quit-line should be established. Services for the deaf (TTY) and multilingual speakers should be available. The quit-line should be able to provide all services to callers or provide referrals to other entities for full services. Technical assistance should be available. Consideration should be given to selecting the provider of the quit-line by competitive bid.
- Funds need to be allocated toward the research and development of cessation programs, particularly those targeted towards adolescents and ethnic communities of color.
- Standards for smoking cessation programs and counselors should be established. Coordination with alcohol and drug quality review processes may be beneficial.

What would it cost?

Cessation programs are very expensive. State funding should focus on those who cannot afford ready access to cessation programs: children, low income pregnant women, ethnic communities of color and other low income populations. The CDC uses a complex formula for creating a budget for cessation programs: $1.00 per adult for screening plus $2.00 per smoker for brief counseling. Further calculations are based on data from cessation programs around the country and Washington adult smoking prevalence data. The Centers for Disease Control & Prevention formula for cessation programs ranges from approximately 5.7 million to 22.5 million dollars (annually), including costs for brief interventions for smokers, and for funding for cessation programs for different percentages of the smoking population. To fund approximately 50 percent of what the CDC recommends, approximately $11.26 million should be earmarked for cessation programs. Included in these figures is establishment of the quit line.

Total Annual Budget for Recommendation 3: $11.26

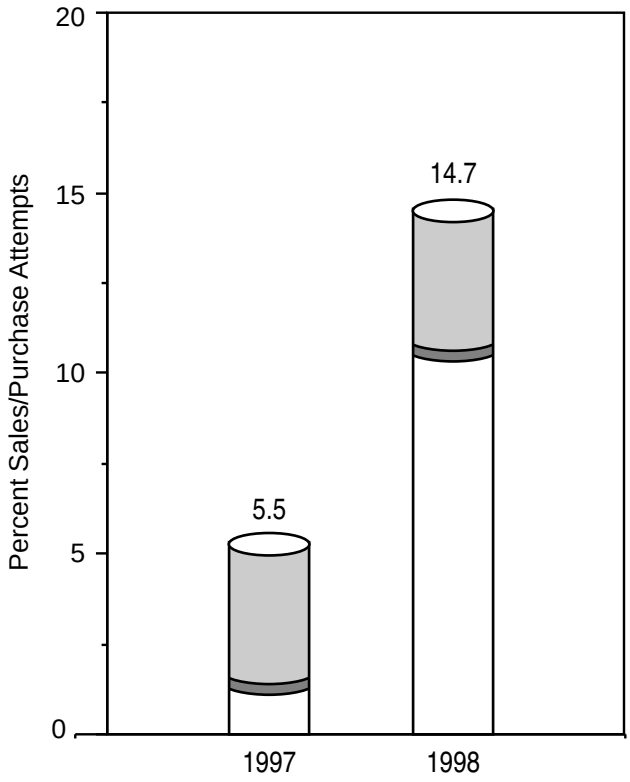
Total Biennial Budget for Recommendation 3: $22.52

Recommendation No. 4: Reduce Youth Access to Tobacco by Strengthening our Laws and Increasing our Enforcement Efforts.

The fourth recommendation of our comprehensive tobacco control plan requires strengthening our laws, continuing to educate our retailers, and increasing our enforcement efforts.

Although all states prohibit the sale of tobacco to minors, the inspector general of the Department of Health and Human Services found in 1992 that only two states were enforcing their access laws. In response, in 1992 Congress passed the SYNAR Amendment which required all states to adopt laws prohibiting the sale and distribution of tobacco products to minors under age 18, to implement enforcement programs, and to provide annual reports to DHHS demonstrating that access to tobacco is being curtailed. Failure to comply jeopardizes state block grants for substance abuse prevention and treatment programs. Specific details regarding implementation of the SYNAR Amendment was left up to the states.

Tobacco Sales to Minors
Washington State 1997-1998



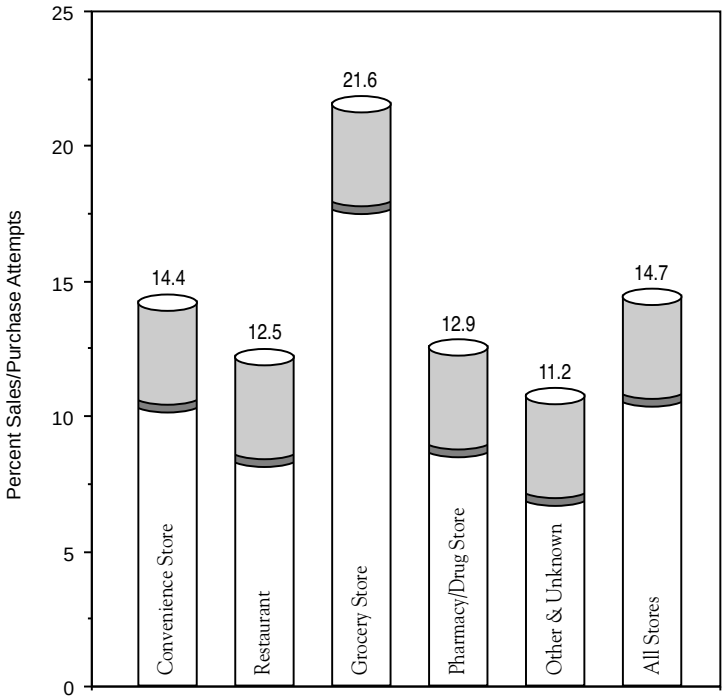
Source: DOH, Tobacco Compliance Data, 1998

What works in other states?

When it is more difficult for minors to purchase tobacco, consumption is reduced. In Woodridge, Illinois two years after the passage and successful enforcement of youth access legislation, the number of seventh and eighth grade students surveyed who reported having experimented with cigarettes had decreased from a pre-ordinance rate of 46 percent to a post-ordinance rate of 23 percent. The number of students surveyed who described themselves as smokers had decreased from 16 percent to 5 percent. In Leominster, Massachusetts, after active law enforcement of local age restrictions on tobacco sales, the number of students who identified themselves as smokers decreased from 22.8 percent to 15.8 percent at post-test two years later.

The status in Washington Washington adopted legislation to comply with the SYNAR amendment in 1993 through RCW 70.155. The Washington State Liquor Control Board enforces this youth access legislation. In 1997, Washington compliance checks of retailers revealed that undercover buyers for WSLCB were able to purchase tobacco only 5.5 percent of time, however, tentative figures for 1998 show an increase to 14.7 percent. Washington is one of four states whose compliance rate was under 20 percent. While this is a success, further reduction of youth access to tobacco is the goal since we know that youth tobacco use has not declined overall. The principal weakness in Washington's

Tobacco Sales to Minors by Type of Store
Washington State 1998



Source: DOH, Tobacco Compliance Data, 1998

legislation is the preemption of local jurisdictions' regulation of tobacco. This preemption section was added to the legislation during the passage of the 1993 bill as a concession to the industry to ensure passage of the legislation needed to meet the Synar amendment. King County's experience reflects the effect of this type of provision.

In the late 1980's King County passed a tough youth access law. The law was enforced by educating retailers, using underage youth in "sting" operations, imposing fines on violators and enlisting the media to increase public pressure on merchants. The underage buying rate was measured at 66 percent before the law was enacted. King County reduced illegal sales to minors to 5 per cent by 1997. It was expected that King County's experience would serve as a model for other local jurisdictions. However, with the passage of preemption, some of King County's efforts could not be continued.

In August 1996, the Food & Drug Administration issued regulations aimed at reducing youth access to tobacco through a variety of advertising restrictions and enforcement tools aimed at retailers. Because of an appeal of those regulations, only two regulations are in effect (1) no sale of cigarettes and smokeless tobacco to anyone under 18 years of age, and (2) the requirement that retailers check photographic identification for anyone under 27 years old. In addition to enforcing Washington state law, the Washington State Liquor Control Board is the designated state agency to enforce the Food and Drug Administration's retailer compliance requirements.

Currently the Washington State Liquor Control Board has six agents dedicated to tobacco enforcement and retailer education statewide. In addition, the WSLCB works with local health departments to provide random inspections of retailers. We can reach more retailers educationally, and enforce our laws more effectively, if we increase funding to this area.

While it is important that penalties for selling products to our children remain stiff to encourage compliance with federal and state law, we must also work with the retailing community providing retailer education as an important component to restricting access to tobacco products. Currently, retailers are required to follow both federal and state law. Thus, retailers must be educated in the requirements for both to effectively deal with tobacco prevention issues. Effective programs should be designed to assist retailers and to encourage their partnership in reducing access to tobacco.

In 1998, the Washington legislature added a section to Washington's access law, clarifying that a minor could receive a civil infraction for possessing tobacco. Violators could be required to attend cessation programs, or as an alternative, provide community service. Additional resources for enforcement in this area are needed, as well as the community based programs for cessation services.

Recommendations

The Task Force recommends that the State strengthen our laws and increase enforcement of those laws through the following initiatives:

1. Eliminate state preemption of local regulatory authority
2. Continue to increase compliance with the retailer tobacco-licensing program through enforcement and education.
3. Prohibit distribution of free samples
4. Prohibit self-service displays
5. Ban single cigarette sales
6. Educate merchants to reduce illegal sales of tobacco and point of sale tobacco advertising aimed at youth
7. Increase enforcement of the minor possession ban
8. Begin research in the area of "social sources" for tobacco, i.e. where our youth access tobacco outside of purchasing products, and developing programs to curb access in this area.

What would it cost?

Currently, the Washington State Liquor Control Board (LCB) coordinates enforcement and retailer education statewide. Local health jurisdictions also conduct compliance checks and work in partnership with LCB to coordinate efforts. To increase enforcement efforts, and to add additional resources for educational activities directed at retailers, the Legislature should appropriate approximately $1.3 million for the biennium ($650,000 annually) to the Washington State Liquor Control Board. The CDC recommends approximately $1 million annually to fund enforcement issues annually in Washington state; this money should be used to fund local health departments' efforts to work in conjunction with the Washington State Liquor Control Board.

Total Annual Budget for Recommendation 4: $1.65 million

Total Biennial Budget for Recommendation 4: $3.33 million

Recommendation No. 5: Community-Based Programs should be Funded through the Department of Health to Local Lead Agencies* in Every County.

Our fifth recommendation for a comprehensive and sustained prevention and control plan requires communities, and individuals, to be active participants in tobacco use reduction.

Communities are frequently the best source of leadership and innovation. Community-wide programs that involve parents, schools, mass media, youth, and community organizations therefore strengthen the effectiveness of school-based prevention programs. Community interventions can help change community norms and practices relevant to youth tobacco use (e.g., enforcement of youth access to tobacco laws). Community-based interventions include youth-based programs, community coalitions, involving community members in efforts to restrict advertising, enforcement of youth access laws, counter-advertising, and others.

Based on reports from the Centers for Disease Control and Prevention and the experiences of other states, effective programs educate communities about the short and long-term consequences of tobacco use, build local commitment to changing social norms surrounding tobacco use, and mobilize communities to combat tobacco use and exposure. Effective programs involve communities in the planning and implementation of strategies and inventions and build community partnerships and involve representatives such as:

- Individual and community leaders
- Community businesses and merchants
- Ethnic and cultural groups
- Youth organizations
- Schools
- Parent associations
- Government agencies, including public health and local elected officials
- Social service agencies
- Law enforcement and the courts
- Health care professionals

What works in other states?

The following are examples of community-based tobacco prevention programs in other states.

California The California Department of Health Services administers dedicated tobacco prevention funds through its Tobacco Control Section (TCS). The goal of TCS is to achieve a social norm that supports a tobacco-free lifestyle and environment for all Californians. All programs under TCS jurisdiction focus on involving the family and community as well as the individual. Policy development is included whenever possible. Local agencies and community-based organizations are involved in

**Local Lead Agencies refers to either local health departments, or in some cases, local community agencies who provide tobacco prevention services on contract with the local health department.*

delivering local programs. Local health departments may serve as designated local lead agencies that organize and staff coalitions, offer some tobacco-related services directly, and offer grants to community-based organizations. Citizen groups working with local programs are active in helping to pass local ordinances by educating communities about the risks of tobacco use and secondhand smoke, and the industry's tactics for reaching and targeting their communities. California maintains four statewide ethnic networks and eleven regional community linkage projects. The Tobacco Education Clearinghouse is also supported by TCS and provides materials at low or no cost to community-based organizations and schools.

California provides $26.6 million in funding to the Local Lead Agencies (FY 96-97) and awards competitively another $31 million for community-based interventions and programs.

Massachusetts The Massachusetts Tobacco Control Program (MTCP) funds contracts with local boards of health to enact and enforce local ordinances designed to make it harder for youth to buy tobacco products from vending machines and retail establishments, and to protect the public from environmental tobacco smoke. MTCP also funds Youth Tobacco Education and Leadership Programs to reach pre-adolescents and adolescents to prevent and reduce tobacco use. Peer leaders conduct direct outreach to youth and hold a variety of community events with tobacco prevention themes. MTCP funds local programs to reach at-risk populations, targeting racial, ethnic and gender groups. Nineteen local tobacco control coalitions receive funding to engage in grass-roots community mobilization around tobacco use and environmental tobacco smoke issues. Funds also support ten regionally based Primary Care Prevention Centers that provide consulting, technical assistance and training for community-based programs and schools.

Massachusetts provides $13.9 million annually (FY 1996) to support local community-based initiatives, excluding an additional $3.3 million for local cessation programs.

Oregon The Oregon Health Division has established Local Coalitions and Community-Based Programs as one component of their Tobacco Prevention and Education Program. Similar to California, Oregon uses local health departments as designated Local Lead Agencies (LLAs) for community-based activities. Meeting minimum requirements is a condition of funding. All LLAs must address reducing youth access to tobacco and must address creating tobacco-free environments. They must demonstrate linkage with schools to create or improve tobacco free environments for students and staff. LLAs must also conduct an assessment of content and enforcement of schools' tobacco policies. Larger counties with 15,000 people or more must also address decreasing advertising and promotion or linking with cessation resources. The largest counties (population >150,000) must do all of the above. Additional local priorities may be addressed in addition to the minimum requirements.

For fiscal year 1997-98, the Oregon Health Division awarded $3.2 million for local community-based activities. Base dollars are determined by population size in order to support some or all of a local staff coordinator. All remaining dollars are awarded based on per capita. Smaller counties received a minimum of $10,000 while Oregon's most populated county received $469,000.

The status in Washington

Currently the Washington State Department of Health funds youth tobacco prevention programs in 33 local health jurisdictions and one community-based organization, reaching all counties of the state. Funds are extremely limited, however, with the smallest counties receiving less than $3,000 per year. DOH also provides additional funds to a limited number of counties.

In addition to the local efforts in the health jurisdictions, there are five sites addressing tobacco prevention and control - Spokane, Snohomish, King, Clark, and Pierce counties. Each of these tobacco prevention sites provides educational information to their communities, develops and maintains local coalitions, designs and implements tobacco prevention activities for youth, and coordinates a variety of community-wide prevention activities. These programs are directed by the State Department of Health and funded by the National Cancer Institute. The state Department of Health provides technical assistance across Washington to all citizens as well as to all the prevention sites.

Recommendations

In Washington, community mobilization grants should be available throughout the state to allow local leadership to continue to develop programs that are specific to their local population's needs. A community mobilization program already exists through the Department of Community, Trade and Economic Development and may be a good mechanism for tobacco grants. Each local community varies in their use patterns, the types of tobacco used, and the prevalence among different populations within their community. Community mobilization programs would allow local organizations to work with local groups to lower their tobacco use rates.

An effective community-based program in Washington should include:

- Merchant and community education coordinated with active enforcement of youth access to tobacco laws to decrease tobacco sales to minors
- The support of existing programs or development of new programs in local health jurisdictions schools, voluntary agencies, law enforcement, agencies and other community organizations dedicated to youth tobacco prevention and cessation
- School-linked community programs that educate parents about adolescent tobacco use to help them communicate with their children
- Communication with sponsors of sporting events to voluntarily ban tobacco advertising on their premises
- Mobilization of parents to speak with their children about not using tobacco; evidence exists that these types of programs change students' perceptions regarding tobacco use.
- Development of public/private partnerships to fund tobacco prevention activities at the state and local level
- Mobilization of youth to participate in tobacco free advocacy within schools and the community, to improve peer knowledge about tobacco, and to promote negative attitudes toward tobacco use

- Promotion of public health policies that encourage tobacco-free community norms. These policies can focus on clean air, taxes, access restrictions, product regulation, insurance coverage for treatment, cessation activities, restriction on local advertising and promotions, and tobacco ingredients disclosure
- Development of tobacco control programs that reflect the values of culturally diverse populations and create the infrastructure necessary to serve these populations. Programs should be developed in conjunction with high risk populations and their community leaders
- Development and maintenance of a clearinghouse of materials, including language-appropriate materials, for communities, schools, cessation.

Programs should incorporate the following two approaches:

- Fund local lead agencies in every county through the Department of Health with participation by the Statewide Oversight Committee to coordinate local coalitions and community based activities
- Fund other community-based activities through a competitive process administered by the state Department of Health

What would it cost?

The Centers for Disease Control & Prevention recommends a range of $1.00 to $2.50 (annually) per capita, plus training and infrastructure amounts of $1,000,000 to $1,500,000 (annually), resulting in a range of $6.4 to $15.07 million (annually) for programs to reduce tobacco use in communities. The Task Force recommends that $1.75 per capita be allocated to local programs. Using a population figure of 5.4 million, $9.5 million should be funded annually. $1.2 million should be allocated for state-wide training and infrastructure.

Total Annual Budget Recommendation 5: $10.7 million

Total Biennial Budget for Recommendation 5: $21.4 million

Recommendation No. 6: The State Must Invest in an Ongoing Public Education and Awareness Campaign.

The sixth component of our comprehensive and sustained effort at tobacco prevention centers on getting our message out to our youth through a quality advertising campaign that rivals the tobacco industry's campaign to lure our youth to a lifetime of addiction.

To replace the more than 400,000 customers that die annually and those who quit from tobacco use, tobacco companies aggressively pour substantial resources into advertising and promotion. According to the Federal Trade Commission, the tobacco industry spent $5.1 billion in advertising and marketing in 1996. Over the past two decades, the tobacco industry has nearly quadrupled its marketing expenditures even while tobacco consumption overall has been in decline.

Of the millions per day the tobacco industry spends on advertising, much of it targets ethnic communities. Examples of this targeting include the sponsorship of cultural and sporting events such as rodeos, pow-wows, ethnically oriented music events, advertising blitzes for particular brands of tobacco in ethnic newspapers and neighborhoods. Culturally and linguistically appropriate anti-tobacco advertising is needed in a broad variety of state and local minority owned media. Culturally competent public education and advertising campaigns should also target age, gender and immigrant subgroups in communities of color in order to maximize their effectiveness. Counter-advertising should also target the special populations of blue collar workers, gays and lesbians, and pregnant women.

Research from the early-1970's show that public education in the form of counter-advertising messages depresses cigarette consumption much more than pro-smoking advertising encourages it.[27] Although several states are beginning comprehensive tobacco control programs that include public education, only the California and Massachusetts counter-advertising programs have been in place long enough to measure effectiveness. Independent studies of these state programs show that counter-advertising works most effectively as part of a comprehensive tobacco control program.

Tobacco advertising effectively reaches one of its main targets – children. Recent documents uncovered in state lawsuits provide evidence that a primary target of the industry's marketing efforts is children. Although federal law bans tobacco advertising on television and radio, the industry advertises and promotes its deadly products where youth will frequently see them: billboards near schools, buses and taxis, magazines with a high percentage of youth readers, sports and arts sponsorships, and product placement in movies and television shows. The tobacco industry ensures through giveaway products that many adults and children become walking advertisements for the industry by wearing their apparel. Washington's public education campaign needs to be as pervasive, frequent, imaginative, and aggressive as the industry's messages.

Assuming a multi-state settlement of the tobacco litigation occurs, our public information campaign should work in partnership with any national campaign. It is critical to our state that we have a program designed to appeal to our residents specifically. Any counter-advertising campaign must integrate its message with our school and community based programs. By coordinating national and local programs, we ensure that our message will be seen as often as the industry's message.

What works in other states?

California A March 1998, study published in the Journal of the American Medical Association showed that smoking consumption dropped dramatically in California — 12.2 percent in one year — as a direct result of their anti-tobacco media campaign.[28] In addition, 40 percent of those surveyed had quit smoking and cited the state's tobacco ads as a factor in their decision to stop. The advertisements were halted for one year when funding ceased. As a result, smoking rates stabilized. When funding was reinstated and the advertisements resumed, rates again began to decline.

Massachusetts A recent independent study of Massachusetts' campaign showed its program was working. As is the case in California, Massachusetts counter-marketing campaign is a single piece of its comprehensive tobacco control plan. Overall, in three and a half years of program activity, tobacco consumption declined faster than national rates, adult smokers smoked less than before the program

began, youth smoking trends were more favorable than the nation as a whole, non-smokers exposure to environmental tobacco smoke was reduced, and merchants increased compliance with the prohibition on tobacco sales to minors.

The status in Washington

Washington is covered by three major electronic media markets - Seattle, Yakima and Spokane. Although some areas receive media from neighboring states, Washington media serves the majority of the population. Broadcast media (e.g., television and radio) reach the following percentages in the state: 98 percent of homes use television; while approximately 95 percent use radio.

Washington state is diverse geographically with highly populated urban centers and rural areas with light population density. The Cascade Mountains create a geographic separation between eastern and western Washington. Media markets outside of Washington state serve border cities (e.g., Vancouver, WA). Specific regional considerations include high concentrations of Spanish-speaking individuals and families in the Yakima and Tri-Cities areas, Soviet immigrants in the Spokane area, and many Southeast Asian immigrants in the Puget Sound area. Reaching such diverse populations will require good segmentation and targeting and custom messages that are both linguistically and culturally appropriate.

Current counter advertising efforts in Washington are minimal. Funding is not available to support a statewide coordinated campaign. As funds permit, local campaigns are conducted using mainly transit advertising and billboards, with occasional use of television and radio. In the 1993-95 biennium, the Legislature appropriated $1 million to the Department of Health to address teen risk behaviors (alcohol, tobacco, and sexual abstinence) through counter-advertising. The campaign was a success in that youth heard the messages, but the Legislature did not appropriate funds in subsequent biennia.

Recommendations

A successful counter-marketing campaign in Washington should utilize mass media, be seen repeatedly, and attract the attention of the target audience. It should include, but not be limited to:

- **Outdoor Advertisements:** billboards, store-front displays, taxis and buses, indoor and outdoor sport venues, bus stops …
- **Electronic Media:** television, radio, Internet, movie theater promotions …
- **Print Media:** newspapers, school and community publications, magazines with emphasis on publications with high youth readership …
- **Special Events and Promotion:** To engage local media and reinforce school and community programs … Kick Butts Day, Great American Smokeout, etc. …

Effective messages which resonate with the intended target audience are critical to the success of any public education campaign. The California study found that the most effective tobacco prevention and control messages focus on industry manipulation and environmental tobacco smoke (ETS). While the tobacco industry does not approve of this strategy, research has proven many times that hard-hitting messages are the most effective.

Research shows that quick-fix campaigns often meet with little success.[29] Thus, an effective campaign with long-term funding commitment is critical. The strongest public education campaigns are those that repeat messages often, are tailored to specific audiences, integrate messages with community and school-based programs, address health and media literacy issues, and promote participation by the target audience.

Because counter advertising can be sensitive, the program must be based on what works and not necessarily what may be politically correct. The campaign should be developed with input from a youth advisory committee. The campaign should also be coordinated statewide, yet designed in conjunction with local communities. It should recognize Washington's racial, ethnic, and regional differences while using central themes tailored to local markets and specific target audiences.

What would it cost?

The Task Force recommends that the maximum recommended by the CDC should be used for this recommendation given the significant expenditures by the industry in advertising and marketing. The Centers for Disease Control & Prevention recommend a range of $1.00 per capita to $3.00 per capita (annually) be spent on public education and counter advertising. Recommendation 6 should be funded at approximately $3.00 per capita, or $16.3 million dollars, keeping in mind that the industry figures are much higher.

Total Annual Budget for Recommendation 6: $16.3 million

Total Biennial Budget for Recommendation 6: $32.6 million

Recommendation No 7: Evaluate Programs on a Regular and Ongoing Basis to Ensure We Have the Best and Most Effective Programs. Conduct Research in Tobacco Addiction and Prevention.

As part of our comprehensive and sustained tobacco control program, the Tobacco Task Force recommends the plan include: (1) a strong *evaluation* component, that assures that the goals of the program are being met, and (2) a strong *research* component, that develops and tests new approaches to tobacco control, thereby providing the means for continually upgrading and improving program components, and adding new programs as needed.

The need for evaluation and research in public health programs is widely recognized. The Washington State Public Health Improvement Plan (PHIP) states: "All public health jurisdictions, both state and local, must...develop and evaluate prevention and control measures, research strategies, and policy options."[30]

Evaluation and research must be integrated into the tobacco control program from the program's beginning. Experience has shown adding the evaluation after a program is in progress is undesirable, and usually results in a more expensive, less useful evaluation. For example, well-done evaluations commonly depend upon baseline data collected before a new program is implemented so the program's effects can be measured over time. Similarly, such data are often gathered in both intervention and comparison areas to assess that the program is making a difference.

Evaluation and research must be adequately funded. Under-funded evaluations that use cheaper, less valid methods may result in findings that are inconclusive or are misleading. This places severe restrictions on any inferences that can be made, and makes it hard to measure the effectiveness of a program.

Need for Evaluation

- Evaluation of a comprehensive tobacco control program is much more than simply monitoring state-wide tobacco use rates. Each component of the program should be evaluated and monitored. An evaluation can determine ways to implement a program more efficiently.
- Programs need to be modified and adapted so they fit the needs and unique characteristics of diverse communities and ethnic groups. Evaluation is necessary to ensure needed changes are made and kept in a sustained program. Communities strongly desire local data as to whether their particular approach is working.
- Ongoing evaluation promotes the continuous improvement of the program as it adapts to changing circumstances over time and ensures that we are receiving our money's worth from the program.

Need for Research

- Research provides the means to develop and test new approaches to tobacco control. Key questions about tobacco control remain to be answered. For example, while tobacco cessation programs are proven effective in adults, there is insufficient scientific evidence that existing smoking cessation programs work in teenagers.
- Research is necessary for Washington's tobacco control program: to remain state-of-the-art, to address new issues in tobacco control as they arise, and to improve methods of evaluating tobacco control programs.
- Research provides a mutually beneficial linkage between community agencies and groups and experts in research.
- Research is necessary in ethnic and other diverse communities to establish baseline data and to establish priorities for reaching these communities, and to ensure that these high risk populations are being reached.

What works in other states?

California and Massachusetts have allocated some of their tobacco control resources to evaluation of program impact and activities. Because each of those states received funding at different times, the level of information available from each varies.

California As stated earlier in this report, California's Proposition 99, approved in 1988, resulted in approximately $100 million per year being designated for tobacco control activities. Numerous tobacco control activities took place through local health departments, community-based organizations, schools, agencies working with high-risk populations, and an extensive statewide anti-tobacco media campaign. The funds were administered by the State Department of Health. The State DOH gave a contract to the University of California-San Diego (UCSD) to conduct regular outcome surveys of adults and youth.[31]

IOX Assessment Associates conducted an independent assessment of the media campaign's effectiveness.[32] In a study conducted a year after the campaign began, IOX found that almost 70 percent of smokers had seen the campaign. After asking about reasons smokers had quit, IOX concluded that the media campaign provided an important stimulus to up to 40 percent of Californian smokers to stop smoking.[33] San Diego State University (SDSU) received a contract to independently monitor and track the number and nature of tobacco control programs implemented across the state. SDSU concluded that the dedicated tax was an effective approach to tobacco education and control.[34] The University of Southern California (USC) conducted an evaluation of the response of the tobacco industry to Proposition 99 activities.

Massachusetts As part of Massachusetts' Question 1 initiative, the state excise tax on cigarettes was increased, with funds dedicated for tobacco control. Independent evaluation of the programs created with Question 1 funds have been conducted by ABT Associates.[35] A baseline Massachusetts Tobacco Survey was conducted by the Center for Survey Research at the University of Massachusetts in Boston. A cancer registry to monitor morbidity and mortality due to tobacco-related factors was also established. A preliminary examination of the media campaign in Massachusetts suggests that it played a role in reduction of smoking.[36] An analysis of 186 focus groups of youth in various states in the USA indicated that Massachusetts' youth were more knowledgeable about smoking and reasons for quitting than youth in other states.[37] Information from most of the other evaluation agencies has not yet been published.

What would a good evaluation and research program look like?

Both California and Massachusetts recognized that a good evaluation program is one that is independent of the programs themselves. The primary reason for this is that an independent evaluator is able to step outside of the program and be objective in assessing the program itself. A good evaluation program should adhere to the following principles:

- Independent organizations plan and implement the evaluation.
- Evaluation is as scientifically rigorous as possible and uses the best available scientific methods.
- Evaluators have significant expertise and experience in conducting program evaluation.
- Participating program organizations are mandated to collaborate with evaluators in data collection.
- Reports of the evaluators are not censored in any way by program organizers.
- Scientific reports are published, and findings are disseminated to communities without censoring by any program organizers, state agencies, or others.

A good research program should adhere to the following principles:

- Opportunities are available for all constituents in the state to apply for research funding.
- Research applications from community groups are made a priority.
- A peer review process is held to determine what applications should be funded.
- Opportunities are made available for community groups to collaborate with research groups in preparing proposals.

- Rigorous scientific design should be followed to the extent possible.
- Scientific reports are published, and findings are disseminated without censoring by any program organizers, state agencies, or others.

Recommendations:

Based on the experiences in other states and the principles of good evaluation and research, we recommend that:

- The state-wide partnership should develop consensus on evaluation and research priorities for programs that emerge from any tobacco control settlement. The consensus should be based upon input from diverse groups (e.g., not-for-profit agencies, schools, experts, community members, health voluntary organizations).
- An independent organization should be selected to conduct evaluation of programs that emerge from any tobacco control settlement (e.g., school-based programs, access to and use of cessation programs, community-based programs to prevent tobacco use by children; effectiveness of public education campaign). The organization may propose collaborating with other agencies/groups/ organizations/individuals to maximize the expertise available for evaluation. The organization should form appropriate partnerships with community agencies, and provide technical assistance to communities in evaluation issues. The organization would have core funding for essential, ongoing evaluation tasks, and could compete for supplemental funding when additional evaluation priorities are identified.
- Community groups, individuals, and other organizations are invited to apply for and are selected to conduct research projects related to the tobacco control program in accord with the research priorities established by the state-wide partnership.
- A peer-review process is used to select organizations that receive monies for either evaluation or research.

What would it cost?

The CDC recommends that about ten percent of the total costs of a tobacco control program be devoted to evaluation and research. Based on the recommendations in this report, $4.5 million should be allocated for research and evaluation.

Total Annual Budget for Recommendation 7: $4.5 million

Total Biennial Budget for Recommendation 7: $9.0 million

Recommendation No 8: Further Consideration of the Following Policy Changes are Important to a Comprehensive and Sustained Tobacco Control Plan.

Tobacco Control Policy Development and Planning

As its final recommendation, the Tobacco Task Force believes that certain policy issues merit further consideration. These policy considerations are aimed at changing the social environment and giving the message that tobacco use is not acceptable behavior. In addition to the policy changes outlined earlier in the report, the Tobacco Task Force makes the following recommendations:

- Eliminate exposure to environmental tobacco smoke (ETS) through restrictions at work-sites and in restaurants, health care facilities, bowling alleys, bingo halls, bars and taverns, and all schools including college campuses. A special focus should be placed on eliminating ETS exposure to children through education and regulation of smoking in locations where children are present.
- Remove any state preemption of local jurisdictions regarding clean indoor air restrictions
- Reduce the amount of tobacco promotion and advertising
- Create economic disincentives to sell or buy tobacco

The Task Force believes that moving in the direction of implementation of these policy changes will strengthen a comprehensive and sustained tobacco control plan.

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Attorney General's Task Force

Co-Chairs

Washington State Department of Health: Maxine Hayes, MD, MPH

Dr. Hayes is the assistant Secretary of Community and Family Health. She oversees the statewide coordination of the Women Infants and Children (WIC) nutrition program, Maternal and Child Health (MCH) program, the Family Planning program, Health Promotion program, Heart Disease and Cancer Prevention program, Immunizations program, TB Control program, HIV/AIDS and STD program, and the Chronic Conditions and Injury Prevention program.

In addition, she is acting health officer for the Washington State Department of Health. In this position, she serves as health agency contact for non-emergency situations requiring the attention of the health officer. She represents the agency publicly, and is the contact with the news media. She is also clinical associate professor of pediatrics at the University of Washington School of Medicine, and on the MCH faculty in its School of Public Health.

Washington State Medical Association: Robert D. Jaffe, MD

Dr. Jaffe is a family physician and health educator in Seattle. He is project director of the Washington SmokeLess States, a community intervention on tobacco control involving six Washington counties, as well as Native American and Asian/Pacific Islander communities. He is the Director of Media and Policy Development at Washington DOC, a health advocacy organization, and serves as the chair of the Washington State Medical Association's Tobacco Control Task Force. Dr. Jaffe's efforts to reduce adolescent tobacco use rates received a 1980 letter of recommendation from Surgeon General Novella and the American Medical Association and the American Public Health Association Journal on how the tobacco industry successfully targets youth. He is the co-author of the *American Medical Association Guidelines on Smoking Cessation*.

Task Force Members

American Cancer Society: David Harrelson

Mr. Harrelson is the Program Manager for Tobacco Control for the Western Pacific Division of the American Cancer Society. He has been on staff with the Division for sixteen years. Mr. Harrelson also is in his eighth and final year as co-project manager of the American Stop Smoking Intervention Study (ASSIST), as he has since the beginning of the project. Previously, he worked on a variety of health promotion and community organizing projects with the YMCA of Greater Seattle, and as a consultant for the Comprehensive Health Education Foundation.

American Cancer Society: Ann Marie Pomerinke

Ms. Pomerinke was appointed Chief Executive Officer of the Western Pacific Division of the American Cancer Society in August, 1992. A 23-year veteran of the Society, Ms. Pomerinke has a solid base in Society affairs, including three years as deputy chief executive, two as NW Washington director, and five in the division's cancer control department. She also brings a unique grass-roots level point of view from her early days as a field representative for six counties in the southwest area of the state.

American Cancer Society: Frances Popstojanovic-Holmstrom

Ms. Popstojanovic-Holmstrom is Vice President for Cancer Control for the Western Pacific Division of the American Cancer Society, which includes Washington, Oregon, Montana and Alaska. She oversees all of the Western Pacific Division prevention, detection, quality of life, information delivery and advocacy programs. She also serves as ACS Project Director for the Assist project in Washington state. During her 13 years with the American Cancer Society here and in Florida, Frances has provided leadership in local, state and national tobacco control initiatives.

American Heart Association - NW Affiliate: Sandra Hijikata

Sandra Hijikata is the Executive Vice President for the American Heart Association, Northwest Affiliate. In this capacity she is responsible for the overall management, revenue generation, public policy, communication, and education efforts for the AHA in the states of Washington, Oregon, Montana, Idaho and Alaska.

American Heart Association - NW Affiliate: Frank Jose, MSW

Mr. Jose is the Director of Advocacy for the Northwest affiliate of the American Heart Association, serving Alaska, Idaho, Montana, Oregon, and Washington. He has a Masters of Social Work from the University of Washington and is an affiliate instructor with its School of Social Work. He has worked in health and human services for 25 years in management, planning, program development, advocacy, and direct service.

American Lung Association of Washington: Astrid Berg

Ms. Berg has served as executive director for the American Lung Association of Washington for the past ten years. Her leadership with the Association and in the community has generated good will and good energy for public health initiatives focused on lung health, including advocacy, research and education programs to reduce tobacco use and improve air quality. She serves on a number of advisory boards related to lung health and is an active member of the Seattle Rotary Club. Her work with the national American Lung Association includes recent services as president of the Nationwide Congress of Lung Association staff.

Comprehensive Health Education Foundation: Larry Clark

Mr. Clark is vice president of Comprehensive Health Education Foundation (CHEF) where he is responsible for leading and managing health education programs and activities for the foundation. He has been with the foundation for more than 15 years where he has served in a variety of positions. Mr. Clark has just completed leading the foundation through a strategic planning process that will guide it for the next ten years. Outside of his work with the foundation, Larry serves on several boards. He is currently president of Pacific Northwest Grantmakers Forum, the regional association for grant-makers.

Comprehensive Health Education Foundation: Carl Nickerson, Ed.D.

Dr. Nickerson is the founder and president of the Comprehensive Health Education Foundation (CHEF) of Seattle. Carl has helped develop education programs for over 30 years, drawing from experience as a classroom instructor, direct coordinator, state supervisor for health education, and work as a national consultant. He earned his masters and doctorate in health education from the University of Oregon. Under his leadership, CHEF has been a pioneer in developing research-based school health education resources and health education philanthropy. He has received numerous state and national awards for his professional contributions.

Fred Hutchinson Cancer Research Center: Beti Thompson, Ph.D.

Dr. Thompson is a scientist at the Fred Hutchinson Cancer Research Center and an associate professor in the School of Public Health and Community Medicine at the University of Washington. Dr. Thompson has been involved in numerous smoking cessation research projects in the past 14 years. Her specialty is behavior change through community-level programs. She was principal investigator for the Community Intervention Trial for Smoking Cessation (COMMIT) in Washington state, and consults regularly at the national and state levels to The American Stop Smoking Intervention Study for Cancer Prevention (ASSIST). Dr. Thompson has contributed to surgeon general's reports on smoking. She is currently principal investigator of 3 NIH-funded projects on smoking control.

Governor's Office of Health Policy: Duane Thurman

Mr. Thurman is a health policy advisor to Governor Gary Locke. Formerly, Mr. Thurman was a policy analyst for the Health Care Policy Board, served as an Assistant Attorney General in the Antitrust Section and Complex Litigation Unit, and was an associate attorney with a Seattle law firm. After graduating from law school in 1986, Mr. Thurman served as law clerk to Supreme Court Justice Robert F. Brachtenbach.

Group Health Cooperative: Tim McAfee, MD, MPH

Dr. McAfee has been a family practice physician at Group Health Cooperative in Seattle for over a decade. He obtained his medical degree from University of California San Francisco and a Masters in Public Health in Epidemiology from UC Berkeley. He completed residency training at Group Health and a faculty fellowship at the University of Washington Family Medicine Department, where he is a clinical faculty member. In 1996, he was the first managed care leader to complete the Scholars Program of the CDC/UC California Public Health Leadership Institute.

Preventive medicine is his special area of interest. He is director of Group Health's Center for Health Promotion. He is also the chair of Group Health's Committee on Prevention, Medical Director of Patient Education, and Medical Director of Tobacco Prevention Services. In this last role, he has been active developing strategies to decrease tobacco use, including provision of medical coverage for cessation services, increased clinic-based smoking prevention and cessation interventions, and population-based activities such as magazine articles, counter ads, and work in the legislative arena. He is also involved in smoking cessation and prevention research, and is a member of the CDC Healthy People 2000 task force on tobacco.

Office of the Superintendent of Public Instruction: James J. Coolican, M.Ed.

Mr. Coolican is Deputy Superintendent of Public Instruction for the Office of the Superintendent of Public Instruction. After retiring from a thirty year career in the United States Marine Corps in 1990, Mr. Coolican has since served as Director of Instructional Services, Director of the Risk Prevention Center, and as a counselor for Educational Service District #101 in Spokane.

Office of the Superintendent of Public Instruction: Denise Fitch

Ms. Fitch has a Master's degree from Lewis and Clark College in Portland, Oregon. Currently, she is the Director of the Safe and Drug Free Schools for the Washington State Office of the Superintendent of Public Instruction, which oversees the Prevention and Intervention Services, Enhancement of School Security, Alcohol Awareness, and the Safe and Drug Free Schools and Communities programs. Denise is a former health and physical education instructor, and is affiliated with a number of national professional organizations.

Sisters of Providence Health System, Peace Health: Diane Stollenwerk

Ms. Stollenwerk is the System Director of Government Affairs for two Catholic health systems: the Sisters of Providence Health System, which includes the Providence Health Plans, in addition to Peace Health (operated by the Sisters of St. Joseph of Peace). As the policy strategist, she coordinates federal advocacy for these systems across several states along the West coast, in addition to being the lobbyist for a large portion of Catholic health care in Washington state. Diane focuses on proactive action, analysis and response to legislation and regulation affecting health care and insurance, welfare, immigration and other social service issues. As a member of the Planning Department within the Providence Health System, she assists in weaving federal and state government policy information into communications and strategic planning for hospitals, health plans, long term care facilities, primary care clinics, home health and hospice, and low-income housing.

Spokane Regional Health District: Kim Marie Thorburn, MD, MPH

Dr. Thorburn is the Health Officer of Spokane County and Director of Spokane Regional Health District. She has worked diligently to guide local tobacco control policy initiatives in her community and participates on the Tobacco Free Washington-Spokane Coalition. Formerly a practicing internist, her fervor for public health approaches to tobacco control stem from her many years of caring for patients with tobacco-related

Students Mobilizing Others Out of Tobacco Habits (SMOOTH): Anna Markee

Ms. Markee is the only youth member of the task force. She is the president of SMOOTH, a youth tobacco-free coalition. SMOOTH paints murals, educates children, and attends local health fairs and other events. In 1997 she was named National Youth Advocate of the Year for the Campaign for Tobacco-Free Kids. Ms. Markee also volunteers with The American Cancer Society, and was the spokesperson for the ACS Speak Out Initiative. Ms. Markee is seventeen years old and is a Senior at Henry Foss High School in Tacoma. She plans to major in Communications or Film and Television.

Tobacco Free Washington Coalition: Tom Wiedemann

Mr. Wiedemann is president of Tobacco Free Washington and a health educator with the Snohomish Health District. He has worked extensively with Snohomish and Skagit County schools coordinating and helping to implement youth prevention activities and promoting student involvement in the community. Mr. Wiedemann serves on the Board of Directors of the Snohomish County chapter of the American Cancer Society and works with the Mount Vernon High School media education project.

Tulalip Tribe: Karen Fryberg

Ms. Fryberg is the Health Administer for the Tulalip Tribe.

University of Washington School of Public Health and Community Medicine: David Buchner, MD, MPH

Dr. Buchner is Director of the Northwest Prevention Effectiveness Center (NWPEC), and professor in the School of Public Health and Community Medicine at the University of Washington. He is also Research Coordinator for Northwest Center for Outcomes Research at the VA Puget Sound Health Care System. The NWPEC theme is "Keeping Older Adults Healthy and Independent." With its community partners, the NWPEC has done many research projects to understand how lifestyle factors affect health, and to understand how best to promote healthy lifestyles.

Virginia Mason Medical Center: Joel Wakefield

Mr. Wakefield serves as the Director of Government Relations and Senior Legal Counsel for Virginia Mason Medical Center in Seattle, Washington. He serves as the liaison between Virginia Mason and state and federal government on health policy issues. Mr. Wakefield also provides legal counsel to Virginia Mason in a wide array of health related areas.

Washington DOC: Nancy Golosman

Ms. Golosman is Executive Director of Washington DOC (Doctors Ought to Care). Ms. Golosman has ten years of community organizing and substance abuse prevention experience. She has special expertise in tobacco control and prevention, working with high risk youth, mobilizing communities, and parent education. As executive director of Washington DOC, Ms. Golosman is the program manager for SmokeLess States, a national project funded by the Robert Wood Johnson Foundation. She manages tobacco use prevention programs in six communities in Washington state. Ms. Golosman has chaired the Tobacco Free Washington Communications Task Force, and has been actively involved in restricting outdoor advertising of tobacco products in Washington state. Washington DOC is known for it's involvement of youth in policy issues related to tobacco control, leadership in community advocacy and creating and providing effective educational programs in Washington state.

Washington State Association of Black Health Professionals: Alvin J. Thompson, MD, MACP

Dr. Thompson is a committed student of and consultant on health policy with over 50 years of clinical experience, practice, medical teaching, and community leadership. He is currently a clinical professor of medicine at the University of Washington School of Medicine. Dr. Thompson is associated with a vast array of professional organizations including past presidencies of the Washington State Medical Association, King County Medical Society, Governor of the American College of Physicians for Washington and Alaska, and a member of the Institute of Medicine. Dr. Thompson is an appointee of the National Institute of Health and the King Country Board of Board of Health and has been awarded several professional honors including the Master for leadership in medical education and the Public Health by the American College of Physicians.

Washington State Association of Local Public Health Officials: Willa A. Fisher, MD. MPH

Dr. Fisher is a local health officer for the Bremerton-Kitsap County Health District. She has been active in development and implementation of tobacco control legislation/policies at the local, state, and national levels. She is past chairperson (1993-95) of the Policy Task Force for the Tobacco Free Washington Coalition, and was a member of Labor & Industries' Indoor Air Quality Advisory Committee (1992-94). She is past chair and current member of the National Association of County and City Health Official's (NACCHO) Tobacco Prevention and Control Committee. Dr. Fisher, a board certified pediatrician, is a graduate of University of California Santa Barbara, University of California San Francisco Medical School, University of Hawaii School of Public Health and University of Washington's pediatric residency program.

Washington State Board of Health: David H. Albert

Mr. Albert is a senior health planner for the Washington State Board of Health. He is author and editor of the Washington State Public Health Report, which by statute sets the state's health priorities and action strategies for each biennium. He holds degrees from Williams College, Oxford University, and the University of Chicago's Committee on Social Thought. He is married with two children.

Washington State Department of Health: Ellen S. Silverman, Ph.D.

Dr. Silverman is a psychologist (focus on Community & Health) and a registered nurse. She is employed as a tobacco prevention specialist with the Washington State Department of Health. Dr. Silverman works with the ASSIST (American Stop Smoking Intervention Study on Tobacco) program as well as other tobacco prevention issues throughout Washington state. Dr. Silverman addresses technical concerns about tobacco cessation, youth tobacco possession, and clean indoor air. Her research includes a cross-cultural study on the Stages of Behavior Change model for which she received a Fulbright to study in Hong Kong

Washington State Department of Social and Health Service: Fred Garcia, MSW

Mr. Garcia is Chief Programs Officer for Washington State's alcohol and drug authority. In this position he leads a large staff to develop, implement, and evaluate policies and programs concerning the prevention and treatment of alcohol and other drug problems.

Prior to arriving in Washington state, Mr. Garcia was President Clinton's choice to assume the duties of the Deputy Director for Demand Reduction within the White House Office for National Drug Control. After leaving the White House in 1996, Mr. Garcia joined the United States Department of Justice, Office of Justice Programs where he served as Senior Advisor to the Assistant Attorney General. Mr. Garcia is a nationally known drug advocate for programming for children and families and has authored several publications concerning working with high risk youth. The most important part of his resume is that he is father of a 13 year old daughter.

Washington State Department of Social and Health Services: Kenneth D. Stark, M.Ed., MBA

Mr. Stark has worked in the alcohol/drug field since 1971. As director of the Division of Alcohol and Substance Abuse, he was awarded the 1993's Governor's Management Award. As a counselor and manager, he has operated residential and outpatient treatment programs. His experiences include adult and adolescent specialties as well as prison-based services. During the 1980's he managed hospital-based inpatient treatment programs and later was president, and one of the principals, of several comprehensive outpatient treatment clinics.

Mr. Stark is currently the Research Committee Chair for the National Association of Alcoholism and Drug Abuse Directors. He has also served on the National Committee for Women's Services for the Substance Abuse and Mental Health Services Administration within the Department of federal Department of Health and Human Services.

Washington State Hospital Association: Brenda Suiter, MHS

Ms. Suiter is the Director of Consumer Policy at the Washington State Hospital Association. She is the policy lead on issues under the policy objective of promoting improved accountability of the health system for consumers, community, and health providers in Washington state. She also serves as the liaison with the Department of Health on policy issues. She has a Masters in Health Services Administration from the University of Washington, 1997 and a BA in Business Administration, University of Washington, 1989.

Staff:

Office of the Attorney General: Donna Fisher

Office of the Attorney General: Elaine Rose

Office of the Attorney General: Brian Smith

Office of the Attorney General: Jennifer Strus

Washington State Department of Health: Stephen Bowman

Washington State Department of Health: Lisa LaFond

Washington State Department of Health: Judy Schmidke

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University of Washington School of Adolescent Medicine

University of Washington School of Pharmacy

Washington Education Association

Washington State Lottery Commission

Appendix

The following table illustrates the guideline recommendations from the Centers for Disease Control and Prevention and the recommendations of the Attorney General's Task Force. The CDC developed its guidelines through evidence-based analysis in California and Massachusetts and intense involvement with settlement states. Basis for the Task Force recommendations can be found within each section of report.

	Centers for Disease Control and Prevention	**Attorney General's Task Force**
Statewide Oversight Committee	5% of the total budget	$2,250,000
School-Based Programs	$4,704,000 - $7,056,000	$4,960,000
Cessation Programs	$5,658,359 - $22,449,054	$11,260,000
Youth Access to Tobacco*	$750,000 - $1,500,000,	$1,000,000
Community Based Programs	$6,430-940 - $15,077,350	$10,700,000
Public Education	$2,715,470 - $16,292,820	$16,300,000
Research and Evaluation	10% of total budget	$4,500,000

** Does not include specific Washington State Liquor Control Board budget figures presented.*